FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATED TO PHYSICIAN PAYMENT UNDER THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

JUNE 15, 1987

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FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATED TO PHYSICIAN PAYMENT UNDER THE MEDICARE PROGRAM

MONDAY, JUNE 15, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:14 p.m., in room 1100 Longworth House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, JUNE 5, 1987

PRESS RELEASE #17
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATED TO PHYSICIAN PAYMENT UNDER THE MEDICARE PROGRAM

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives announced today that the Subcommittee will hold a hearing on Fiscal Year 1988 budget reconciliation issues related to physician payment under the Medicare program. The hearing will be held on Monday, June 15, 1987, beginning at 1:00 p.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said, "The purpose of the June 15 hearing is to review budget reconciliation options related to physician payment under Medicare. The Subcommittee has already held three hearings related to physician payment this year. At the June 15 hearing, the Physician Payment Review Commission will present its recommendations for Fiscal Year 1988 budget reconciliation."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The Budget Resolution for Fiscal Year 1988 adopted by the House includes Medicare reconciliation savings of $1.5 billion in FY 1988, $2.7 billion in FY 1989, and $4.0 billion in FY 1990. The Resolution adopted by the Senate includes reconciled Medicare savings of $3.0 billion in FY 1988, $3.5 billion in FY 1989, and $4.6 billion in FY 1990.

On June 11 and 12, the Physician Payment Review Commission will meet to consider a number of FY 1988 reconciliation options related to physician payment. One approach being considered by the Commission involves selective reductions in payment for certain medical or surgical procedures for which current payment levels appear to be excessive. A second approach is to reduce the scheduled 3.2% payment update for physicians.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, June 29, 1987, to Robert J. Leonard, Chief Counsel Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

COMMITTEE ON WAYS AND MEANS FORMATTING REQUIREMENTS FOR PRINTING OF HEARING STATEMENTS, WRITTEN COMMENTS AND EXHIBITS

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. The Subcommittee on Health of the Committee on Ways and Means will begin the hearing on fiscal year 1988 budget reconciliation issues, first from the administration on overall budget reconciliation matters, and then more specifically direct our attention to matters related to payment of physicians under Medicare.

As we consider the options for physician payment, it is important that we think in terms of a long-term reform strategy, and any short-term adjustments we make in reconciliation this year should be consistent with our long-term goals.

It is my view that we have three major goals for long-term reform. First, and foremost, the continuing increase of out-of-pocket costs for physician services must be capped or stopped and, hopefully, reduced.

Second, we have to have more accurate controls over program outlays.

Third, and perhaps most importantly, both regional and urban and rural and all the inequities we have discussed must be corrected in whatever system we use. This necessitates contemplating complex reforms, for a complex system.

In 1984, we established the participating physician program to give the elderly the opportunity to choose a physician who agrees in advance not to extra-bill. Last year, we improved the program by providing a number of incentives for participation. These efforts appear to be beginning to work.

In 1986, we also established limits on extra billing for nonparticipating physicians. Finally, we have begun to reform payment rates. Last year's budget legislation focused on selected overpriced procedures. This year, we should build on those foundations. To assist us, we have asked the Physician Payment Review Commission to develop a series of options for fiscal year 1988 reconciliation. I am pleased to report the Commission has developed recommendations that can help us meet our budget goals and move the system in the right direction.

The focus of the Commission's recommendation is that budget savings should be obtained by reducing payment for selected overpriced procedures. The Commission also recommends that undervalued services, such as office visits, should be protected from budget cuts.

These recommendations make sense, and they will be carefully considered by the subcommittee. We must also strengthen the participating physician program to make sure that budget cuts do not result in increased costs for the elderly.

Following Dr. Roper's testimony, we will focus on the recommendations of the Physician Payment Review Commission presented by Dr. Phil Lee. Finally, the physician groups will have an opportunity to respond to the Commission's recommendations.

At this time I am pleased to welcome back Dr. William Roper, the Administrator of the Health Care Financing Administration. Welcome back to the committee, Bill. You may proceed in any manner you are comfortable.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. ROPER. Thank you, Mr. Chairman and members of the committee. I will summarize my statement and submit the entire statement for the record.

Chairman STARK. Without objection.

Dr. ROPER. I am pleased to be here today to discuss the administration's recommendations for reconciliation in Medicare and Medicaid. These proposals reflect the administration's continuing commitment to slowing the growth of Medicare program expenditures, while maintaining a high level of quality in the program. We believe they make an appropriate contribution to achieving the overall budget savings necessary this year.

Before I begin discussing reconciliation items, though, there are two top priorities for our agenda that I want to draw your attention to. The first is our strong and increasing emphasis on activities that promote quality in health care, and secondly, our desire to expand the use of private health plans in the Medicare program. We believe that competition and choice for beneficiaries and providers will be an important improvement in the program.

Let me move now to our recommendations for budget reconciliation. These proposals taken together would have fiscal year 1988 savings of $4.3 billion, $41 billion over the next 5 years.

We are recommending for fiscal year 1988 an update to the prospective payment system rates for hospitals of three-quarters of 1 percent, and 1.9 percent in payments to hospitals excluded from PPS. We believe this modest increase will avoid financial disruption in hospitals while allowing the program to benefit from improvements in hospital behavior prompted by the system. This will allow $780 million in program savings next year and $5 billion over 5 years.

Further, let me say again we believe it is essential to restore the discretion of the Secretary in setting PPS rates. We believe that the past practice of the Secretary setting the rates and the Congress reserving the right to change those rates, if you find it necessary to do so, is the appropriate practice for the future.

We propose to reduce inappropriate payments to hospitals for indirect medical education costs by eliminating the arbitrary doubling of the indirect medical education payment adjustment. Last year, you lowered those payments, but we believe you did not go far enough to correct unnecessary overpayments. An adjustment factor of 4.05 percent would produce savings of $835 million next year and $6 billion over 5 years.

Further, we are proposing to limit payment for direct medical education to only those costs associated with clinical care of Medicare patients, saving $310 million next year and $1.8 billion over the next 5 years.

The hearing you are having today focuses largely on physician payment reform, and in this budget we are recommending several changes in the physician payment area, all focused on the central purpose of making targeted changes in physician payment.

A recent analysis of Medicare payment for physician services showed that Medicare expenditures for physician services grew at twice the rate of non-Medicare expenditures for these services. We believe a number of changes are warranted. In the aggregate, these would save $190 million next year and $1.5 billion over 5 years.

Specifically, we propose to establish a more reasonable payment rate for cataract surgery. This remains one of the highest priced procedures even after last year's reductions.

We also propose to pay for radiologist, anesthesiologist and pathologist services performed in a hospital on an average price prospective basis.

We are also asking beneficiaries to bear an appropriate part in achieving necessary budget savings by expanding Medicare coverage of State and local employees to those hired before March 31, 1986. A majority of these retirees qualify for Medicare through previous jobs or spousal entitlement. Bringing these individuals under the program will bring in $1.6 billion in revenue next year and $10 billion over 5 years.

We also propose to restructure the Medicare part B premium to restore a more equitable balance between general revenue and premium financing. Federal subsidies for current enrollees would remain at 75 percent; new enrollees would be subsidized at 65 percent, and third-party payers would be subsidized at 50 percent of costs. These additional changes would bring in additional premium income of $571 million next year and $15.7 billion over the next 5 years.

We are also proposing to index and automatically update the part B deductible to changes in the MEI.

Before concluding, I want to mention a proposal that we believe should definitely not be included in this year's reconciliation bill. A few weeks ago, we published our proposal to reform capital payments to hospitals. This would gradually establish prospective payment for capital over the next 10 years. This is a regulation that is greatly improved from last year's, improved through being responsive to the concerns of the hospital industry and others. This proposal is budget neutral to the limits the Congress imposed for fiscal years 1988 and 1989.

We again urge you not to extend or again impose a moratorium on our ability to use the regulatory process to reform Medicare payment for capital.

To retain the current cost reimbursement method for capital is to continue Medicare payment for unoccupied beds. Retaining cost reimbursement would only be appropriate, we believe, if some adjustment for declining occupancy were also made. However, I urge you to permit us to go forward with our proposal to reform payment for capital.

In conclusion, we believe these are sound proposals that balance the goals of quality, access, but also cost in the program, and are pleased to discuss them with you.

Thank you very much.

[The statement of Dr. Roper follows:]

STATEMENT OF WILLIAM L. ROPER, M.D. BEFORE THE
HOUSE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH
JUNE 15, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I AM PLEASED TO BE HERE TODAY TO DISCUSS THE PRIORITY ITEMS THE ADMINISTRATION RECOMMENDS FOR INCORPORATION INTO THIS YEAR'S RECONCILIATION BILL. THESE PROPOSALS REFLECT THE ADMINISTRATION'S CONTINUING COMMITMENT TO SLOWING THE GROWTH OF MEDICARE PROGRAM EXPENDITURES, WHICH CONTINUE TO RISE AT LEVELS THAT SUBSTANTIALLY EXCEED THE RATE OF GROWTH OF THE GENERAL ECONOMY, WHILE MAINTAINING A HIGH LEVEL OF QUALITY HEALTH CARE. ENACTMENT OF THE ADMINISTRATION'S PROPOSALS WILL ASSURE THAT MEDICARE PROGRAM SAVINGS MAKE AN APPROPRIATE CONTRIBUTION TO ACHIEVING THE OVERALL BUDGET TARGET IN FY 1988.

BACKGROUND

WHEN THIS ADMINISTRATION TOOK OFFICE, MEDICARE PROGRAM EXPENDITURES WERE RISING AT OVER 20 PERCENT A YEAR. BY 1986, THAT GROWTH DECLINED TO 8 PERCENT. WE ARE PROUD TO HAVE ACCOMPLISHED SLOWING THE RATE OF INCREASE IN SPENDING BY WORKING WITH CONGRESS AND THE PRIVATE SECTOR. OUR REFORMS HAVE POSTPONED THE PROJECTED BANKRUPTCY OF THE HOSPITAL INSURANCE TRUST FUND AND SLOWED THE BURDEN OF GENERAL REVENUE FINANCING OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND. THESE REFORMS HAVE ALSO STIMULATED DRAMATIC CHANGES IN THE HEALTH CARE SYSTEM THAT HAVE RESULTED IN A WIDE RANGE OF NEW AND MORE EFFICIENT DELIVERY SYSTEMS AND IN A MORE COMPETITIVE MARKET PLACE.

BEFORE I GO ON, I WANT TO MENTION TWO FY 1988 PROPOSALS WHICH, WHILE NOT RECONCILIATION ITEMS, REMAIN A TOP PRIORITY ON OUR AGENDA FOR THE COMING YEAR. FIRST, THIS ADMINISTRATION IS COMMITTED TO MAINTAINING AND ENHANCING A HIGH LEVEL OF QUALITY THROUGHOUT THE MEDICARE AND MEDICAID PROGRAMS. OUR BUDGET FOR FY 1988 REFLECTS A STRONG AND INCREASED EMPHASIS ON ACTIVITIES TO PROMOTE QUALITY HEALTH CARE. SECOND, IT IS OUR BELIEF THAT MAINTAINING QUALITY AND CONTROLLING THE GROWTH OF HEALTH CARE COSTS CAN BEST BE ACCOMPLISHED THROUGH THE EXPANSION AND EXTENSION OF COMPETITION AND CHOICE FOR BOTH BENEFICIARIES AND PROVIDERS. OUR PROPOSALS FOR EXPANDED USE OF PRIVATE HEALTH PLANS WILL MAKE AN IMPORTANT CONTRIBUTION TO ACHIEVING THESE GOALS.

RECONCILIATION PRIORITIES

LET ME MOVE NOW TO OUR RECOMMENDATIONS FOR BUDGET RECONCILIATION. THE PROPOSALS I WILL DISCUSS TODAY WOULD ACHIEVE ESTIMATED SAVINGS IN FY 1988 OF $4.3 BILLION AND $41.1 BILLION OVER THE NEXT FIVE YEARS, AS MEASURED AGAINST THE BASELINE THAT IS GROWING AT AN UNSUSTAINABLE RATE.

PPS UPDATE FACTOR

WE ARE RECOMMENDING AN FY 1988 UPDATE TO THE PROSPECTIVE PAYMENT RATES FOR HOSPITALS OF 0.75 PERCENT, AND 1.9 PERCENT IN PAYMENT TO HOSPITALS EXCLUDED FROM PPS. SINCE HOSPITALS GENERALLY HAVE BEEN DOING WELL UNDER THE PROSPECTIVE PAYMENT SYSTEM, WE BELIEVE THIS MODEST INCREASE WILL AVOID FINANCIAL DISRUPTION IN HOSPITALS WHILE ALLOWING THE MEDICARE PROGRAM TO BENEFIT FROM IMPROVEMENTS IN HOSPITAL BEHAVIOR PROMPTED BY THE SYSTEM. USING THESE UPDATES, MEDICARE WILL REALIZE $780 MILLION IN PROGRAM SAVINGS IN FY 1988 AND $5 BILLION OVER FIVE YEARS, COMPARED TO CURRENT LAW.

FOR FY 1988 AND BEYOND, WE BELIEVE IT IS ESSENTIAL TO RESTORE THE DISCRETION OF THE SECRETARY IN SETTING THE PPS RATES. THE SECRETARY NEEDS THE FLEXIBILITY TO ESTABLISH REALISTIC RATES NECESSARY TO ASSURE THAT HOSPITALS AND THE MEDICARE PROGRAM AND

BENEFICIARIES ARE REAPING THE REWARDS OF MORE EFFICIENT HOSPITAL PERFORMANCE.

PAYMENT TO HOSPITALS FOR THE INDIRECT MEDICAL EDUCATION COSTS

WE PROPOSE TO REDUCE INAPPROPRIATE PAYMENTS TO HOSPITALS FOR THE ADDITIONAL COSTS ASSOCIATED WITH TEACHING PROGRAMS BY ELIMINATING THE ARBITRARY DOUBLING OF THE INDIRECT MEDICAL EDUCATION PAYMENT ADJUSTMENT. THE PAYMENT ADJUSTMENT WAS SET TOO HIGH IN THE ORIGINAL LEGISLATION AND RESULTED IN WINDFALL PROFITS TO TEACHING HOSPITALS. RECENT CONGRESSIONAL ACTION TO REDUCE THE ADJUSTMENT DID NOT GO FAR ENOUGH TO CORRECT UNNECESSARY OVERPAYMENTS. OUR PROPOSAL WOULD SET THE INDIRECT MEDICAL EDUCATION ADJUSTMENT FACTOR AT 4.05 PERCENT AND PRODUCE SAVINGS OF $835 MILLION IN FY 1988 AND $6 BILLION OVER 5 YEARS.

OTHER RECONCILIATION PROPOSALS WOULD IMPROVE EFFICIENCY IN AREAS WHERE WE CONTINUE TO PAY ON THE BASIS OF COSTS OR CHARGES. PROPOSALS INCLUDE REFORMS IN HOW MEDICARE PAYS FOR GRADUATE MEDICAL EDUCATION AND REFORMS IN PHYSICIAN PAYMENT.

GRADUATE MEDICAL EDUCATION

WE ARE PROPOSING TO LIMIT PAYMENT FOR DIRECT MEDICAL EDUCATION TO ONLY THOSE COSTS ASSOCIATED WITH THE CLINICAL CARE OF MEDICARE PATIENTS. OUR PROPOSAL WOULD ELIMINATE CURRENT SUBSIDIES FOR CLASSROOM AND OTHER EDUCATIONAL COSTS. WE WOULD ALSO ELIMINATE PAYMENTS FOR THE DIRECT COSTS OF TRAINING NURSES AND OTHER ALLIED HEALTH PROFESSIONALS. MEDICARE PAYMENT FOR GRADUATE MEDICAL EDUCATION WAS INTENDED ONLY TO BE A TEMPORARY SUBSIDY UNTIL COMMUNITIES COULD ASSUME THE RESPONSIBILITY FOR TRAINING HEALTH CARE PROFESSIONALS. WE BELIEVE IT IS DIFFICULT TO JUSTIFY CONTINUING THIS LEVEL OF DIRECT MEDICAL EDUCATION PAYMENTS. REDUCING PAYMENTS FOR DIRECT MEDICAL EDUCATION COSTS WILL SAVE $310 MILLION IN FY 1988 AND $1.8 BILLION OVER THE NEXT FIVE YEARS.

PHYSICIAN PAYMENT REFORM

THROUGH THE BUDGET RECONCILIATION PROCESS, WE HOPE TO INCREASE PHYSICIAN EFFICIENCY INCENTIVES BY MAKING TARGETED CHANGES IN PAYMENT. A RECENT ANALYSIS OF MEDICARE PAYMENTS FOR PHYSICIAN SERVICES IN 1985, SHOWED THAT MEDICARE EXPENDITURES FOR PHYSICIAN SERVICES GREW AT TWICE THE RATE OF NON-MEDICARE EXPENDITURES FOR THESE SERVICES. WE BELIEVE THAT THIS DISCREPANCY RESULTS FROM INEFFICIENCIES IN MEDICARE'S PAYMENT SYSTEM THAT HAVE BEEN COMPOUNDED OVER TIME AND DISTORTED BY CHANGES IN TECHNOLOGY AND VARIATIONS IN PHYSICIAN PRACTICE PATTERNS. CORRECTION OF INAPPROPRIATE LEVELS AND VARIATION IN PHYSICIAN PAYMENT WOULD RESULT IN SAVINGS OF $190 MILLION IN FY 1988 AND $1.5 BILLION OVER 5 YEARS.

MORE SPECIFICALLY, WE PROPOSE TO ESTABLISH A MORE REASONABLE PAYMENT RATE FOR CATARACT SURGERY WHICH REMAINS ONE OF THE HIGHEST PRICED PROCEDURES EVEN AFTER THE REDUCTIONS REQUIRED BY THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986. PAYMENT FOR CATARACT SURGERIES SHOULD BE FURTHER REDUCED TO REFLECT TECHNOLOGICAL ADVANCES THAT PERMIT OVER 80 PERCENT OF SURGERIES TO BE PERFORMED IN OUTPATIENT SETTINGS AND IN A MUCH SHORTER TIME.

WE ALSO PROPOSE TO PAY FOR RADIOLOGIST, ANESTHESIOLOGIST AND PATHOLOGIST SERVICES PERFORMED IN A HOSPITAL ON AN AVERAGE PRICE PROSPECTIVE BASIS, THEREBY PROVIDING INCENTIVES FOR APPROPRIATE UTILIZATION AND COST EFFICIENCY. WE ARE PROPOSING TO PERMIT THE SECRETARY TO LIMIT PREVAILING CHARGES FOR CERTAIN MEDICAL OR SURGICAL SERVICES WHERE THERE IS A LARGE DISPARITY BETWEEN THE

CHARGES OF SPECIALISTS AND NON-SPECIALISTS. WE WOULD ALSO REVISE MEDICARE PAYMENT TO NEW PHYSICIANS BY SETTING CUSTOMARY CHARGES AT NO MORE THAN 80 PERCENT OF THE PREVAILING CHARGE. THIS WOULD CORRECT AN INEQUITY IN THE CURRENT SYSTEM WHICH RESULTS IN NEW PHYSICIANS BEING PAID AT HIGHER LEVELS THAN SOME ESTABLISHED PHYSICIANS.

INCREASED BENEFICIARY PARTICIPATION

WE ARE ALSO ASKING BENEFICIARIES TO BEAR AN APPROPRIATE PART IN ACHIEVING NECESSARY BUDGET SAVINGS. BENEFICIARY PARTICIPATION THROUGH VARIOUS REVENUE PRODUCING AND COST SHARING MECHANISMS HAS TRADITIONALLY BEEN AN INTEGRAL PART OF THE MEDICARE PROGRAM AND HAS SERVED AS AN IMPORTANT SOURCE OF INCOME, WHILE HELPING TO ASSURE APPROPRIATE UTILIZATION OF MEDICARE SERVICES.

LET ME MENTION OUR PROPOSALS TO INCREASE BENEFICIARY PARTICIPATION AND COST-SHARING. FIRST, WE WANT TO EXPAND MEDICARE COVERAGE OF STATE AND LOCAL EMPLOYEES TO THOSE HIRED BEFORE MARCH 31, 1986, AS WELL AS AFTER THAT DATE, AS THE LAW CURRENTLY SPECIFIES. A RECENT REPORT BY THE DEPARTMENT'S INSPECTOR GENERAL REVEALED THAT A MAJORITY OF RETIREES FROM EXEMPT GOVERNMENT AGENCIES QUALIFY FOR MEDICARE THROUGH FREVIOUS JOBS OR SPOUSAL ENTITLEMENT. THESE INDIVIDUALS GENERALLY CONTRIBUTE LESS THAN HALF THE MEDICARE TAXES OF OTHER WORKERS, IN FACT MANY MAY CONTRIBUTE NOTHING TO THE TRUST FUNDS, YET THEY ACCOUNT FOR A SIGNIFICANT AMOUNT OF MEDICARE EXPENDITURES -- ALMOST $8 BILLION OVER THE LAST FIVE YEARS. WE ESTIMATE THAT EXTENDING COVERAGE TO THESE INDIVIDUALS WILL BRING IN $1.6 BILLION IN REVENUES IN FY 1988 AND $10.4 BILLION OVER FIVE YEARS.

WE WOULD ALSO RESTRUCTURE THE MEDICARE PART B PREMIUM TO RESTORE A MORE EQUITABLE BALANCE BETWEEN GENERAL REVENUE AND PREMIUM FINANCING, CONSISTENT WITH CONGRESS' ORIGINAL DESIGN THAT THE COSTS BE SHARED EQUALLY. FEDERAL SUBSIDIES FOR CURRENT ENROLLEES WOULD REMAIN AT 75 PERCENT OF PROGRAM EXPENDITURES. NEW ENROLLEES WOULD BE SUBSIDIZED AT 65 PERCENT OF COSTS AND THIRD-PARTY PAYERS WOULD BE SUBSIDIZED AT 50 PERCENT OF COSTS. THIS PROPOSAL WOULD RESULT IN ADDITIONAL PREMIUM INCOME OF $571 MILLION IN FY 1988 AND $15.7 BILLION OVER FIVE YEARS.

WE ARE ALSO PROPOSING TO INDEX AND AUTOMATICALLY UPDATE THE PART B DEDUCTIBLE TO CHANGES IN THE MEDICARE ECONOMIC INDEX. THE ANNUAL DEDUCTIBLE IS NOW $75 AND HAS BEEN INCREASED ONLY TWICE FROM THE ORIGINAL $50 LEVEL IN 1966. OUR PROPOSAL WILL CAUSE THE DEDUCTIBLE TO RISE BY ONLY $2 IN 1988, AND WILL REDUCE OUTLAYS BY $25 MILLION IN 1988 AND $725 MILLION OVER FIVE YEARS.

CAPITAL

BEFORE CONCLUDING, I WANT TO MENTION A PROPOSAL THAT WE BELIEVE SHOULD NOT BE INCLUDED IN THIS YEAR'S RECONCILIATION BILL. JUST A FEW WEEKS AGO, WE PUBLISHED OUR PROPOSAL TO REFORM CAPITAL PAYMENTS TO HOSPITALS. OUR PROPOSAL WOULD GRADUALLY ESTABLISH PROSPECTIVE PAYMENT FOR CAPITAL OVER THE NEXT 10 YEARS. WE BELIEVE THIS CHANGE IS ESSENTIAL TO ELIMINATING THE INCENTIVES FOR UNNECESSARY CAPITAL EXPENDITURES INHERENT IN THE CURRENT COST REIMBURSEMENT APPROACH. OUR PROPOSAL IS SUBSTANTIALLY DIFFERENT FROM LAST YEAR'S -- IN LARGE MEASURE DUE TO OUR EFFORTS TO BE RESPONSIVE TO THE CONCERNS OF THE HOSPITAL INDUSTRY. FURTHERMORE, THE PROPOSAL IS BUDGET NEUTRAL TO THE LIMITS CONGRESS IMPOSED FOR FY 1988 AND 1989. TO RETAIN THE CURRENT PAYMENT APPROACH IS TO CONTINUE MEDICARE PAYMENT FOR UNOCCUPIED BEDS, AT A TIME WHEN HOSPITAL OCCUPANCY CONTINUES TO FALL. IN LIGHT OF THE DEFICIT AND THE NEED TO RESTRAIN MEDICARE OUTLAYS, RETAINING COST REIMBURSEMENT WOULD ONLY BE APPROPRIATE IF SOME ADJUSTMENT FOR DECLINING OCCUPANCY WERE ALSO MADE. INSTEAD OF SUCH AN ACTION, HOWEVER, I ASK YOU TO PERMIT US TO GO FORWARD

WITH OUR PROPOSAL TO REFORM PAYMENT FOR CAPITAL.

CONCLUSION

IN CONCLUSION, WE BELIEVE THAT OUR 1988 MEDICARE PROPOSALS ARE RESPONSIBLE REFORMS THAT MEET THE IMPORTANT OBJECTIVES OF ASSURING BENEFICIARIES THAT THEY CAN CONTINUE TO RELY ON THE MEDICARE PROGRAM FOR QUALITY MEDICAL CARE AND OF REDUCING THE FEDERAL DEBT. THE SELECTED PROPOSALS I HAVE PRESENTED TODAY CAN ACCOMPLISH SIGNIFICANT SAVINGS IN MEETING THE FY 1988 BUDGET TARGET AND MOVE US TOWARD THE GOAL OF A MORE EFFICIENT AND EFFECTIVE MEDICARE PROGRAM.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you very much, Mr. Chairman.

Dr. Roper, I understand that you now have the hospital cost data for 1985, otherwise known as the PPS II data. It would be very helpful to the subcommittee if you could make available to us, perhaps for the record if not right now, data on the average operating margins by type of hospital—teaching, nonteaching, urban, rural—and by type of ownership as well.

It also would be useful if you could tell us what percentage of hospitals in those categories have a margin below zero, based upon the 1985 data.

Dr. ROPER. Yes, sir. We are in the process of assembling that data. It will be a few more days, but we will get that information to you.

[The information follows:]

The information requested by Mr. Gradison has been provided directly to him. In addition, these data have been made available to ProPAC and CBO.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

June 24, 1987

Mr. Charles Kehn
Minority Health Counsel
House Ways and Means Committee
1106 Longworth Bldg
Washington, D.C. 20515

Dear Chip:

As you requested, I am sending tables showing projected Medicare hospital margins for FY 1988 assuming various update factors and rates of increase in hospital costs per case. These margins were calculated by subtracting Medicare costs from Medicare payments and dividing by Medicare payments. Both the costs and payments include inpatient passthroughs, as well as costs (payments) subject to PPS.

The analysis was done using a sample of 4757 hospitals for which we have cost data from the second year of the PPS system. The analysis excludes Massachusetts and New York hospitals because we do not have PPS-2 data for them.

As you can see, hospital margins vary dramatically depending on the assumptions about how rapidly hospital costs have increased since PPS-2. It bears emphasis that we do not know which of the assumptions is closest to correct; it depends on how vigorously hospitals respond to the incentives inherent in PPS, and we do not have a reliable model of hospital behavior.

The projected FY 1988 margins assume current law remains in effect with two exceptions: the update factor varies as indicated in the tables and we assumed implementation of the changes proposed in our NPRM published on June 10. The most important features of the NPRM were: a new wage index; case-weighting; recalibration of the DRG weights; changes in the "grouper" system, including dropping age as a basis for separating DRGs; and a change in outlier policy.

Where we were dealing with unaudited PPS-2 cost reports, we made an across-the-board adjustment to costs to simulate the effects of an audit. The adjustment was based on our experience with data from the first year of the PPS system.

These tables incorporate the effect of the transition to national rates, but we have not had time to differentiate the impact of the transition from the impact of the update factor.

Consistent with our usual practice, we have supplied ProPAC and CBO with copies of the data file used for this analysis.

If we can be of further assistance, please let me know.

Sincerely,

Bill

William L. Roper, M.D.
Administrator

Enclosure

cc: Trisha Knight
Steve Lieberman

FY1988 SIMULATED PPS MARGINS (PAYMENTS - COSTS / PAYMENTS)
INCLUDING PASSTHROUGHS, EXCLUDING MASS. AND NEW YORK
PPS2 COST PER CASE INFLATED TO FY1988 BY TWO TIMES MARKET BASKET

	NUMBER OF HOSPITALS	FY88 UPDATE 1.5%	.75%	0%
NATIONAL AVERAGE	4757	-7.0	-7.7	-8.4
MEDICARE GROUPS				
URBAN	2341	-6.7	-7.4	-8.1
BED SIZE 0-99	586	-1.9	-2.6	-3.3
100-404	1429	-6.7	-7.4	-8.1
405-684	284	-6.6	-7.3	-8.0
OVER 685	42	-10.2	-10.9	-11.6
RURAL	2416	-8.3	-9.0	-9.7
BED SIZE 0-99	1880	-7.6	-8.3	-9.1
100-169	366	-9.9	-10.6	-11.3
OVER 170	170	-7.8	-8.5	-9.2
TEACHING STATUS				
NON-TEACHING	4023	-7.3	-8.0	-8.7
LIGHT TEACHING (LT .25)	620	-6.9	-7.6	-8.2
HEAVY TEACHING (GT .25)	114	-5.0	-5.6	-6.3
DSH STATUS				
NON DSH HOSPITAL	3760	-8.2	-9.0	-9.6
DSH URBAN GT 100 BEDS	714	-4.5	-5.1	-5.8
DSH URBAN LT 100 BEDS	77	0.1	-0.5	-1.2
DSH RURAL	206	1.6	0.9	0.2
SCH/RRC STATUS				
NON SCH/RRC HOSPITAL	4249	-7.0	-7.7	-8.4
SOLE COMMUNITY HOSPITAL	295	-13.0	-13.7	-14.5
RURAL REFERRAL CENTER	179	-4.4	-5.1	-5.8
SCH AND RRC	19	1.8	1.1	0.5
TYPE OF OWNERSHIP				
VOLUNTARY	2816	-7.7	-8.4	-9.1
PROPRIETARY	712	-6.2	-6.9	-7.6
GOVERNMENT	1212	-3.8	-4.5	-5.2
RURAL LT 50 BEDS	1133	-4.9	-5.6	-6.3

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INCLUDING PASSTHROUGHS, EXCLUDING MASS. AND NEW YORK
PPS2 COST PER CASE INFLATED TO FY1988 BY TWO TIMES MARKET BASKET

	NUMBER OF HOSPITALS	FY88 UPDATE 1.5%	.75%	0%
URBAN	2341	-6.7	-7.4	-8.1
NEW ENGLAND	63	-5.7	-6.4	-7.1
MID ATLANTIC	167	-4.6	-5.2	-5.9
SOUTH ATLANTIC	386	-7.3	-8.0	-8.7
EAST NORTH CENTRAL	476	-12.8	-13.5	-14.2
EAST SOUTH CENTRAL	139	-4.1	-4.8	-5.5
WEST NORTH CENTRAL	180	-3.5	-4.2	-4.9
WEST SOUTH CENTRAL	357	-6.2	-6.9	-7.5
MOUNTAIN	92	2.8	2.2	1.5
PACIFIC	481	-5.1	-5.8	-6.5
RURAL	2416	-8.3	-9.0	-9.7
NEW ENGLAND	42	-14.8	-15.6	-16.3
MID ATLANTIC	41	-6.7	-7.4	-8.1
SOUTH ATLANTIC	318	-7.1	-7.8	-8.5
EAST NORTH CENTRAL	352	-14.8	-15.5	-16.3
EAST SOUTH CENTRAL	287	-5.8	-6.4	-7.1
WEST NORTH CENTRAL	561	-6.9	-7.6	-8.3
WEST SOUTH CENTRAL	433	-6.1	-6.8	-7.5
MOUNTAIN	226	-7.4	-8.1	-8.8
PACIFIC	156	-7.4	-8.1	-8.8
ILLINOIS	217	-13.4	-14.1	-14.8
OHIO	184	-14.5	-15.2	15.9
% OF HOSPITALS NEG. MARGINS		64.9%	66.5%	68.1%

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% OF HOSPITALS NEG. MARGINS		64.9%	66.5%	68.1%

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

August 4, 1987

The Honorable Willis D. Gradison, Jr.
Ranking Minority Member
Subcommittee on Health
Ways and Means Committee
United States House of Representatives
washington, D.C. 20515

Dear Mr. Gradison:

I am writing to clarify a June 24, 1987, letter sent to House Ways and Means minority staff by William Roper, M.D., Administrator of the Health Care Financing Administration. That letter provided information, which you requested at a June 15 hearing, on how hospital margins might be affected under various assumptions about Medicare payment and hospital costs. It has come to my attention that the American Hospital Association and others are misconstruing the June 24 analysis, so I personally wanted to clarify it.

As requested, the June 24 analysis included three potential assumptions about hospital costs: that they increase at the rate of market basket inflation, at twice the rate of inflation, and at one-half the rate of inflation. None of these assumptions reflect changes in hospital behaviors which have resulted since the inception of the Prospective Payment System (PPS).

Evidence shows that in response to the new incentives of PPS, hospitals have improved practice patterns and increased efficiency, markedly reducing PPS costs. As our 1986, 1987, and 1988 PPS regulations describe in detail, we believe that more efficient hospital behavior has offset more than half of market basket inflation cost increases.

The projections which we provided you earlier were not prepared by the Medicare Actuary. This non-actuarial analysis employed a different methodology, one which had the effect of reducing projected operating margins. The June 24 analysis revised the formula used to calculate operation margins from the approach we have always used in the past (e.g., the 1985 PPS Report I transmitted to Congress on May 20, 1987). This one methodological change reduced the operating margins in the June 24 analysis.

In addition, the analysis reflected costs and revenues associated with non-PPS items, such as capital and medical education, all of which hospitals allocate to Medicare and which Medicare pays on an open-ended cost reimbursement basis. Operating margin projections associated with only the prospective payment system are significantly higher than those in the June 24 analysis.

Finally, the analysis used 1985 hospital cost data, the most recent available to us. These data are not yet audited. If past experience is any indication, hospitals have allocated many non-Medicare costs to Medicare, greatly shrinking the calculated operating margin on Medicare.

The Medicare Actuary has carefully reviewed hospital costs, Medicare payments, hospitals' responses to the new incentives under PPS, and the resulting operating margins. Based on the analyses he has completed, the Actuary confirms that an update of 0.75 percent is wholly consistent with continued access to high quality care for Medicare beneficiaries and that hospitals will be able to continue to have healthy Medicare operating margins.

In closing, I would like to emphasize that Dr. Roper and I both support the Administration's recommended increase in the PPS rates of 0.75 percent. We believe still great improvements in hospital efficiency are both possible and necessary. In the early years of PPS, hospitals earned substantial profits. The only way to assure hospitals will strive for still further efficiency gains is to apply steady pressure through continued restraint on the PPS rates. We urge you to support our efforts to that end.

Sincerely,

Otis R. Bowen M.D.

Otis R. Bowen, M.D.
Secretary

Mr. GRADISON. Thank you very much.

I understand that you are opposed to the rebasing concept, and that you have argued strongly, according to the press, for an update of more than zero. Could you share with us the reasons for your positions on rebasing and a positive update for fiscal year 1988, please?

Dr. ROPER. I believe the recommendation of 0.75—that is, three-quarters of 1 percent, which is a positive number, as you say—is the appropriate recommendation. Rebasing is a term that is loosely used to mean any of a number of methodologies for recalculating the basic rates under the program.

We stand ready to provide assistance for whatever the Congress chooses to do in this area, but I believe, we believe, that a positive increase of 0.75 percent is the appropriate number at the present time.

The problem I have with giving a general comment on rebasing is that different people mean different things by that.

Mr. GRADISON. That is absolutely true, and that has been brought out in our earlier hearings.

As you know, ProPAC recommended a differential update factor between rural and urban: as I remember it, 3.1 percent for rurals and 2.2 percent for urbans, with an average of 2.3 percent. Do you think there should be a differential in the update for fiscal year 1988?

Dr. ROPER. The numbers we have at hand say that given the changes you made last year in OBRA, the differential between payments to urban and rural hospitals has narrowed significantly. Come fiscal year 1988, the difference will be 14 percent higher on average for urban hospitals as opposed to rural hospitals.

I believe that is about right and have been arguing and would argue today against further narrowing that differential. It seems to me that both our gut level assumption, but also the data, would argue that things are more expensive in urban areas than they are in rural areas. I recently had the chance to go to rural Montana, though, and the folks out there tried to argue me out of that point. But I remain convinced that some slight additional amount—14 percent is what it is going to be come October—is appropriate and would argue against further narrowing that differential.

Mr. GRADISON. Thank you, Mr. Chairman. Thank you, Dr. Roper.

Chairman STARK. Doctor, you want us to reduce the medical education payments by how much? I am trying to recall your testimony.

Dr. ROPER. The amount for indirect medical education is $800 million for next year, and direct is $300 million for next year.

Chairman STARK. How much out over the future? It is about $1.1 billion and——

Dr. ROPER. Almost $8 billion over 5 years total.

Chairman STARK. $8 billion?

Dr. ROPER. Yes, sir.

Chairman STARK. Now, as you know, I have never had any quarrel with that. I mean, I am sure there is a public policy in aiding physicians to get a good education and training, and I suspect we probably get some value back. I gather some of that is reimbursing the hospitals for the expense of training the people, and some of it

is for actually the work they do, for working 100 hours a week for low wages, that there is some benefit.

What has troubled me over these years—and I am going to ask HCFA and/or Health and Human Services—is I can find no logic in paying for it through the Medicare system. I can find some logic in paying for it through the medical delivery system, put a bed tax or a gross fees tax on the fees that physicians collect, or something. And I think historically there was never any legislative history for why it should be here.

So while I have no quarrel, because we do not have any idea—I think the costs there are probably more inaccurate than any of the cost figures we argue about as we go through this process each year. But what about your coming up with an alternate suggestion for how the Federal Government ought to subsidize medical education? Then I would feel much better about saying, okay, let us just get it out of the Medicare system completely.

Have you all ever addressed that? Would you be willing to as an alternative? I mean, I have a hunch there is not time enough to do it this year in reconciliation, but it sure would seem to me we could put that one to rest and not have to be worrying about something, arguing about that ten years from now.

Dr. ROPER. Well, a couple of points. First, the reason Medicare pays for medical education is that 22 years ago, in 1965 when the legislation passed, the Congress said let us continue paying Medicare's share, or let us let Medicare pay its share until society comes up with a better way of doing business.

Second, we are proposing an alternative in that we suggest, instead of paying this amount, the appropriate amount to pay is a lower amount. Our alternative for indirect medical education is to pay what the facts justify as the truly appropriate additional amount that it costs to treat Medicare patients in a teaching hospital.

We believe these hospitals are being overcompensated at the present time and suggest reducing it.

Chairman STARK. I want to see if I am missing something. You pay for it now by an increased percentage on the DRGs?

Dr. ROPER. That is one way. That is the so-called indirect medical education payments. The other way is we reimburse the direct education costs of teaching programs in hospitals, and we are proposing to slim down, to cut that amount, so that we are reimbursing only the direct costs involved in hands-on treatment of Medicare patients.

Chairman STARK. And you think that in your current reporting information you can ascertain those direct costs pretty accurately for each hospital?

Dr. ROPER. Yes, we do.

Chairman STARK. So the only inexact part is the indirect cost?

Dr. ROPER. It is inexact, but we would be pleased to do as we already have done: produce the data that suggests that this is the right number and that the higher current number is too high.

Chairman STARK. And of the two savings, you had $800 and $300 million, which was the higher?

Dr. ROPER. The larger amount is the indirect teaching adjustment to the PPS rates.

Chairman STARK. So what you are saying is that we are paying $300 million where you can account for the costs with some accuracy on a per-hospital, on a real micro sense?

Dr. ROPER. The $300 million figure is the savings off of what we are paying for the, if you will, audited costs of direct teaching expenditures.

Chairman STARK. But you are convinced that that is accurate?

Dr. ROPER. We are spending about $1.5 billion on the direct education costs, and we are proposing to save $300 million off of that.

Chairman STARK. And do you know offhand what we are spending on indirect?

Dr. ROPER. I will get the figure for you. It is several billion dollars.

[The following was subsequently received:]

Estimated expenditures for indirect medical education costs for fiscal year 1988 are $1.9 billion. Our proposal would save $800 million.

Chairman STARK. So that is the part you want to cut out over time?

Dr. ROPER. Well, it is this complicated formula that adds on an amount to the PPS rate. What we want to do is lower the adjustment factor, cut it in half, in fact.

Chairman STARK. But it just appears to me that, and I do not mean this in a pejorative sense, you are just fudging the DRG rates in a kind of an approach on the indirect side to say, it is 10 percent higher.

Dr. ROPER. Sure.

Chairman STARK. Or it is this much higher for an appendectomy in a teaching hospital. And I suspect that that is less accurate than most other things we do.

Dr. ROPER. Could we come up with a fundamentally different way of doing it?

Chairman STARK. Yes.

Dr. ROPER. We would sure be open to that.

Chairman STARK. That is what I am getting at. And then figure out who should pay for it. Now, I suspect Medicaid does not pay for it, and I am not sure Blue Cross pays for it.

Dr. ROPER. Some part of it.

Chairman STARK. For insured directly. I do not suppose that Blue Cross adds an amounts to the hospital. Maybe they do.

Dr. ROPER. Well, most payers do pay a share of the teaching costs, but I think you are right to say that everybody is interested in paying less.

Chairman STARK. Do they calculate it consciously? In other words, if I belong to Blue Cross and I can go to one of several hospitals, does Blue Cross pay the hospital that teaches more?

Dr. ROPER. No.

Chairman STARK. We do in Medicare.

Dr. ROPER. They pay a percentage of bill charges, and teaching hospitals bill higher amounts. But I do not think they discretely separate an amount for teaching costs.

Chairman STARK. But we do, in a sense.

Dr. ROPER. Yes.

Chairman STARK. And that is what I am saying. It is a system that we just keep adding a little bit to or cutting a little bit from and never really are evaluating whether the system is any good. That is, in the long-range sense what we ought to change and figure out why we are doing it.

The other issue in this, is that we have a severe shortage of nurses, and a big chunk of what you are cutting would come out of nursing training.

Dr. ROPER. Yes.

Chairman STARK. Why should we be doing that? Why should we cut some place else if we do, in fact, have a shortage of nurses?

Dr. ROPER. Because the shortage is people who are trained as nurses, who are actively seeking employment as nurses. There is an abundance of individuals in society who are trained as nurses who have chosen, for economic or life style reasons, not to work as nurses. It is primarily an economic question. Hospitals are making adjustments to their working conditions, and are paying nurses more. Training more people as nurses seems to me not to be the answer to the problem.

Chairman STARK. Is this an opinion that is shared by nurses' groups and nurses' training schools?

Dr. ROPER. I do not think so.

Chairman STARK. And hospitals in general?

Dr. ROPER. I do not think so. No.

Chairman STARK. It is conceivable, at least to me, that as are so many other things that are arduous and have low pay, including, I suppose, being in Congress or serving in the Government, that it is increasingly becoming a young person's game. It might be that if we were undertraining the number of nurses in years past, those who had been nursing for longer and had saved enough money to go on and help raise their families or do other things that for some reason are more rewarding, we may have to train more. And on a cost basis, it might be less expensive to recruit new people to an underpaid profession.

Would you want to prioritize that in any way and say that to save some money maybe we ought to reinstate some there as opposed to across the board?

Dr. ROPER. Within the broad category of medical education, I would put a higher priority on cutting the indirect teaching adjustment than the direct medical education costs.

Chairman STARK. In your increasing of the part B premiums, are you familiar with the Social Security notch problem.

Dr. ROPER. In very general terms. I have not studied it in detail.

Chairman STARK. Could you explain it to me why it is fair for somebody born between—what years?

Dr. ROPER. 1917 and 1921, or something like that.

Chairman STARK. Between 1917 and 1921, why is it fair, Dr. Roper, for those people to get a lower benefit than the people born in other years?

Let us assume that this is late October in an election year and this is a town meeting. Now, can you explain to me why we should not straighten out that notch problem?

Dr. ROPER. No, I cannot. I asked Dorcas Hardy that, and she could not explain it to my simple mind. She tells me it is not a problem.

Chairman STARK. She should come to my town meeting.

Dr. ROPER. It is certainly a political problem.

Chairman STARK. Well, it is a political problem, but I would like to suggest that the politicians will view the idea of having two sets of premiums under part B and creating another notch problem as one that would just further confuse us and cause us to answer thousands of letters. Probably the increased postage in answering the letters would knock out the savings.

Dr. ROPER. Well, I take your point. The response I have to give you, though, is we have, for several years running, argued that there ought to be greater cost sharing by beneficiaries. We have not prevailed on that argument, and so to get around the question of cutting Social Security checks or raising premium on already enrolled beneficiaries, we seek to do the latter for future enrollees.

Chairman STARK. OK. But go through this drill with me for a moment. The present premiums are $17.60.

Dr. ROPER. 60 cents.

Chairman STARK. 90 cents, I am told.

Dr. ROPER. Something like that.

Chairman STARK. And it is scheduled next year without any changes to go to $22 even. It goes to $26 in 1992.

Now, if the administration prevailed, what was your flat premium for catastrophic?

Dr. ROPER. It is around $6 now.

Chairman STARK. $6 dollars. So you would have raised it next year to $28, going to $32 without any indexing in 1992, and I suspect your index was even higher. It was up to about $12? OK. It was $8.60 by 1992. So we are up to $34.60.

What would your changing the premium calculation do, say, for next year and 1992? What would it add to those who would be at the higher rate?

Dr. ROPER. You are talking without the catastrophic add-on?

Chairman STARK. No, let us add that in, because one way or another, yours or our more expensive one, will probably be law. I am just trying to add another.

Dr. ROPER. All right. Let me go at it this way. The current premium, you are right, is $17.90 per month. Left alone, it would rise to $26.10 in 1992. Under our proposal, it would rise to—the figures I have in front of me do not—I need to go back and take a look at them.

Chairman STARK. Go ahead. Say them. They are probably right.

Dr. ROPER. Well, it shows the premium for current beneficiaries rising to $34 in 1992, but my question is——

Chairman STARK. What about the ones who come in under the new program?

Dr. ROPER. $48 for new beneficiaries.

Chairman STARK. I think that is probably right, $48, $50.

Dr. ROPER. I have got my thinking straight. Here we go. $17.90 now under current law, which has the 25-percent requirement going away in another year or so. The total premium would be $26.10 in 1992. Under our proposal, which continues at 25 percent

for current beneficiaries, it would rise to $34 in 1992; with catastrophic added on, it would be roughly $40. New beneficiaries rising to $48; with catastrophic that would be $54 by 1992. These are monthly premium figures.

Chairman STARK. I guess that before we wanted to lock ourselves into that kind of a track, and this is just a guess, that we would want to look at the options of increased payroll taxes and an across-the-board increase rather than just new beneficiaries, and a whole host of other options. It appears to me if you add, and I suspect that there may be a somewhat higher increase in the premium through a variety of catastrophic plans that are before us, these premiums might very well be getting out with indexing, or unless we can control costs better, we will have it costing $60, $70.

Dr. ROPER. Yes, sir.

Chairman STARK. And when you are dealing with people, a lot of people with $500–$600 a month in income, that gets to be more than we want to do just on a flat premium. So I suggest that we may have to reason together to find more progressive ways to finance that increase.

I have no quarrel with having people pay their share, but I think as you have seen the mood of both Houses, I think on both sides of the aisle, has been to income-relate more of these costs. I think where this committee would find some concern is in keeping the flat premium awfully high without any concern for some of the lower income side. I think we would want to revisit that.

Dr. ROPER. Mr. Chairman, if I could just add one point. I am sure you are aware the figures I have given you about the costs of catastrophic as a premium are, of course, the administration's proposal without a drug benefit, which we have learned would be even much higher.

Chairman STARK. All right. Ours would increase those even much higher, and I am painfully aware of that.

I wanted to talk with you about one more area, and I have had some discussions with others in the administration. Is it the administration's sense that the fee for service system under which we currently reimburse the majority of physicians has a very causal effect on how medicine is practiced in the aggregate? That is item 1. Item 2, is it the general feeling in the administration, that left unchecked and without some change in direction, costs will escalate even more rapidly than they have been on the physician side of the ledger?

Dr. ROPER. I would say it slightly differently, but I think we are in fundamental agreement.

I began by saying that I believe that the vast, vast majority of doctors in America are practicing responsible, professional medicine. Fee for service, however, gives people an incremental incentive to do more units of service because they are paid by the piece. Therefore, until we come up with some way of paying physicians that deals both with the price and also the quantity, the utilization of health care services, I believe we are going to see continued rapidly rising costs for physician services under the program.

I find few, if any, defenders of the current CPR system for paying doctors under the Medicare program, so the essential question is where do we go in the future. There seems to be a large

amount of interest in reforming the prices that we pay doctors. Some people would have us come up with a national administered price system, a fee schedule, if you will. To me that loses sight of the fact that we would even at that point have no control over, no accountability for, the total units of service.

You are right. Until we deal with both of those, we have got a major, major problem.

Chairman STARK. I tend to agree with you, although you have the advantage of being far more familiar with physicians' practices than members of this committee.

Now, we will hear argument, I am sure, that therefore we should wait to correct some of the fee for service, which is what these expensive procedure recommendations really would be doing.

Dr. ROPER. Yes.

Chairman STARK. Until we can reform the whole system. How do you deal with that criticism of our proposal?

Dr. ROPER. Well, I think there are some things that we know quite obviously now ought to be changed. I mentioned in my testimony lowering payment levels for cataract surgery, for example, and there are some other things that we could do that we are proposing to do.

It would be easier to persuade me to hold off from doing those kinds of things if I had the faith that a year or two years around the corner we were going to have the ultimate solution. I do not think we have yet discovered that ultimate solution.

We believe, as you know, that paying for total services on a capitated basis gives much better incentives for managing care, and I hold that out as the ultimate solution. It is going to take us a little while to get there, however.

Chairman STARK. Well, let me ask this. I do not know the answer. It is my understanding that if we go to at-risk or capitated services, it is a feeling of some who think that will cut over to all costs, that there will be incentive for preventive medicine and annual physicals and things like that. There will be more incentive for that than just dealing with fee-for-service procedures. Therefore, going into the capitation or at-risk system will encourage the groups to take better preventive care of their patients.

Have you considered, or is not an alternative setting down certain minimum standards for the Medicare population at large? Is that a reasonable alternative for us to explore?

Dr. ROPER. It is an understandable alternative. The thought of trying to dictate minimal standards for the practice of medicine to these thousands of doctors is something that would be woefully difficult. But I understand your point.

Chairman STARK. What about the patients? It seems to me if they're backsliding as I am, that's the last appointment they keep for their annual physical. I think I am about 5 years behind on the physical I have every year. I am still getting one from 1972, that is the one I am getting this year. Wouldn't it be of some help if the Medicare beneficiaries were involved in this procedure and had to report in on time or is that not part of the process.

Dr. ROPER. I think it is altogether in the interests of a prepaid plan to have well-informed enrollees who take care of their own

health and come in for care when they need it, even preventive care; so, yes, that is all to be——

Chairman STARK. That could be done under the present system with the fee for services.

Dr. ROPER. It could be, yes.

Chairman STARK. Well, doctor, thank you. Mr. Coyne?

Mr. COYNE. Nothing.

Chairman STARK. Mr. Levin?

Mr. LEVIN. A few weeks ago, I met with some representatives of Henry Ford Hospital and they went through your proposals, or at least what they thought were your proposals. Some of them you are not advocating today. But as I add it up, your proposals would mean a reduction of about $15 million from about $81,500,000 under existing law. That is a reduction for this one hospital from the graduate medical education change and the change in the DRG rate increase. I do not know how much you know about Henry Ford Hospital——

Dr. ROPER. I know it is a distinguished hospital.

Mr. LEVIN. Right. It is in the city of Detroit and provides a variety of services in that setting. What do we say to a hospital like that which would have about a 16 to 17 percent cut in 1 year?

Dr. ROPER. I am not familiar with the particular circumstances of that one hospital, Henry Ford, but what I would say is each of these proposals makes sense on their own and we just have to take a look at how they cumulatively impact on this one hospital. Hospitals that are teaching hospitals, which are the ones that are most affected by these proposals, have been the ones that have benefited the most under the prospective payment system as it has been formulated.

Mr. LEVIN. Well, have you done that? Have you taken your proposals and looked at teaching hospitals like Henry Ford? Looked at their net income figures?

Dr. ROPER. Yes, sir and they have had the widest margin, the most profit, if you want to call it that, in the Medicare program in the last few years.

Mr. LEVIN. And have you also looked at their other activities, what other services, functions these teaching hospitals are providing within the delivery spectrum? In other words, have you looked to see where these are and what else they are providing, and what, not in theory but in practice, your proposals would mean for their income?

Dr. ROPER. Yes, sir.

Mr. LEVIN. So you know that the net income for Henry Ford in 1986, at least this is what we have been told, would be reduced by 16 to 17 percent. Of course, that is the Medicare component. You have actually not only looked at the gross figures but applied your specific proposals to a number of hospitals, teaching hospitals, and you are satisfied?

Dr. ROPER. Yes, sir.

Mr. LEVIN. Do me a favor if you would. Take a look at the Henry Ford Hospital. I will send you the materials. I just picked it up because they were in to see us and they are a hospital with, I think, a very strong reputation and they have a critical function within the

Detroit area and Detroit specifically. If you would, let me send you the materials and give me your analysis.

Dr. ROPER. I will be glad to do that.

[The following was subsequently received:]

Assuming an update factor of 0.75 percent for fiscal year 1988, the estimated increase in PPS payments per discharge to Henry Ford Hospital, exclusive of pass-throughs, would be 1.1 percent. This compares with an increase of 0.8 percent for all urban hospitals and 1.1 percent for all hospitals.

Mr. LEVIN. Have you prioritized your proposals in order of importance as you see them?

Dr. ROPER. No, we have not.

Mr. LEVIN. Do you want to give me any clue as to which you think are more important and less important?

Dr. ROPER. I think they are all important, Congressman.

Mr. LEVIN. All equally important?

Dr. ROPER. The chairman pressed me a minute ago of the medical education proposals, which I felt was the more important, and I gave him an answer on that one.

Mr. LEVIN. No, but I meant more generally.

Dr. ROPER. More generally, I think they are all important. I do not have a set of priorities for you.

Mr. LEVIN. You do not have any feelings of weight among them?

Dr. ROPER. I would want to give that some thought. I have not attempted to assemble priorities.

Mr. LEVIN. We are going to hear some later testimony and I think all of us here have received considerable material about cataract surgery. Your proposal is based on what?

Dr. ROPER. Our conviction that Medicare pays too much for cataract surgery.

Mr. LEVIN. No, where did you get the percentage, the additional percentage?

Dr. ROPER. What we are proposing is to impose, on top of the 12-percent across-the-board reduction that the Congress imposed last year, an additional 13 percent.

Mr. LEVIN. Where does it come from? Where does the 13 percent come from?

Dr. ROPER. Our belief that we have been overpaying by about 25 percent based on comparing the time and effort involved in this surgical procedure with other surgical procedures and the costs involved in the process. So if you are asking is it based on analysis, the answer is "Yes." It is not a number just pulled out of the air.

Mr. LEVIN. No, I knew that. So you have looked at procedures—do you have calculations that are available to this subcommittee?

Dr. ROPER. You mean how we arrived at that number?

Mr. LEVIN. Right.

Dr. ROPER. Be glad to do that, yes.

[The following was subsequently received:]

Our proposal to reduce cataract surgery by an additional 13 percent in fiscal year 1988 is based on a study conducted by the Health Care Financing Administration in 30 hospitals with the largest volume of cataract surgeries. Our study reviewed data from 1980 and 1985 and found that surgeries with intraocular lens implants took only 3 minutes longer than surgeries without lens implants. However our study found that the prevailing charges for the two procedures varied by 55 percent. We concluded that prevailing charges for cataract surgery with a lens implant were overvalued. We therefore developed a proposal to reduce payment for cataract surgery with a lens implant over a 3-year period to 110 percent of the payment for a surgery without a lens implant. This proposal would have resulted in a 25-percent

reduction in payments for cataract surgery in fiscal year 1988. Since current law already provided for a 12-percent reduction, we proposed an additional reduction of 13 percent.

Mr. LEVIN. OK, do you supply them—I am new to the subcommittee—do you supply them as a matter of course? I mean, is this something you usually submit to the committee? Because I think it would be helpful. This is a controversial area and sometimes we do not get a direct confrontation. You testify and then you leave, and then somebody else testifies. It is a little hard to have direct dialogue except between us and the specific witness. So, I think in this case, it would be helpful if you could actually give us——

Dr. ROPER. The basis for our proposal?

Mr. LEVIN. Yes, exactly.

Dr. ROPER. OK.

Mr. LEVIN. Thanks very much. Thank you.

Chairman STARK. Mr. Pickle?

Mr. PICKLE. Well, I want to follow through on the question that Mr. Levin had just proposed to you. Are you saying that cataract surgery, just to begin with, is overpriced by some 13 to 15 percent?

Dr. ROPER. Yes, sir.

Mr. PICKLE. Now, who made that determination?

Dr. ROPER. I did. My agency did based on analysis.

Mr. PICKLE. Do you put a value on appendix surgery? Every kind of surgery possible? Do you have a price set on all these procedures?

Dr. ROPER. No, we have not done across——

Mr. PICKLE. Why do you pick out cataract surgery then, just by itself, and say it is overpriced by 15 percent?

Dr. ROPER. The first reason we pick out, as you say cataract surgery, is 86 percent of the cataract surgery paid for in this country is paid for by the Medicare program; so it is a major part of that market, if you will.

Mr. PICKLE. Well, I understand that, but I am trying to understand the value you put on the operation.

Dr. ROPER. We have done comparing. We have compared the time and effort for doing this procedure with other similar surgical procedures and find that it is much more expensive than other comparable procedures.

Mr. PICKLE. Well, I am not arguing with you. I am just trying to determine how you decided this operation is worth so much.

Dr. ROPER. Yes, sir.

Mr. PICKLE. And if you do not determine this for all other operations, then why single out this surgery? Is it just an individual decision on your part that it is overpriced.

Dr. ROPER. Yes, it is.

Mr. PICKLE. And it may or may not be, but I am trying to get the source of information for that monumental decision.

Dr. ROPER. Congressman, we began this effort a year and a half ago in a regulatory process that we put forward to reduce the amount we paid for this procedure contending it to be an overpriced procedure using our inherent reasonableness authority. We were proposing at that point a 25-percent reduction. The Congress interposed and said only take half of that and our proposal is to come back to you and say the full amount remains justified.

Mr. PICKLE. Well, then tell me how do you arrive at the decision that it is overpriced? How do you determine that it is overpriced?

Dr. ROPER. By comparing it to other surgical procedures; similar kinds of procedures.

Mr. PICKLE. Now, you have made the statement that it is overpriced, and then you said in addition, that is because, I guess, we should make further reductions because of the improvement in technology. That is the argument that I hear more and more. So, you would say reduce it because it is overpriced and, second, make further reductions because of improved technology? Both categories?

Dr. ROPER. We are only proposing one reduction, but we think it is justified for both reasons.

Mr. PICKLE. For two reasons, yes. One is that it is overpriced and secondly, because of the improved equipment, you get it done quicker.

Dr. ROPER. The price is high and it is remaining high despite the fact that more efficient practice allows it to be done more simply, more rapidly and one would think that the price would fall otherwise.

Mr. PICKLE. I notice you also say you would propose to pay for the RAP's to a hospital on an average price prospective basis. Is that the same approach you used now, or are you going to use a different approach for them?

Dr. ROPER. The proposal is to change the basic way we pay for inpatient radiologist, anesthesiologist, and pathologist services.

Mr. PICKLE. Do we have that proposal? I presume, we do, but I have not seen it.

Dr. ROPER. Yes, sir.

Mr. PICKLE. Is it included here?

Dr. ROPER. You held a hearing about a month ago on it. Our legislative proposal is not yet to you but it will be in a few more days.

Mr. PICKLE. All right. Thank you, Mr. Chairman.

Chairman STARK. Bill, just a couple of other questions. You are a physician, correct?

Dr. ROPER. Yes.

Chairman STARK. Would you care to rank the skill required to perform cataract surgery, coronary bypass, hip replacement, prostate surgery, or gall bladder surgery?

Dr. ROPER. In front of all these people?

Chairman STARK. Make them all happy or all mad?

Dr. ROPER. I am a pediatrician and what we do is the most important. I will begin there.

Chairman STARK. Well, let me put it this way. It is my understanding that you pay about $2,200 an hour for cataract surgery. Now, we reduce that by 10 percent. So the reduced rate is now $2,000 an hour under your approved rates and you are paying $990 an hour to a cardiac surgeon for a coronary bypass. Can you explain to me why the difference? Why should I pay twice as much an hour to my cataract surgeon as I do when I get my bypass?

Dr. ROPER. I do not think you should. I think that what you are describing is the artifacts that are built into the way we have paid doctors under the usual, customary, and reasonable methodology over the years.

Chairman STARK. How long does the average cataract procedure take, in time? A couple of hours?

Dr. ROPER. No, I think it is less than that but Dr. Stokes will be up before you shortly, you could ask him that.

Chairman STARK. I understand that you had a study last year that was about 45 minutes?

Dr. ROPER. Something like that.

Chairman STARK. How long does a coronary bypass take? That must take longer.

Dr. ROPER. A couple of hours but, again, I am not your expert on that one.

Chairman STARK. OK, I am told that takes 226 minutes and that is the longest one and you are allowing a $989 charge per hour. OK. So there are some major differences in the prices we pay for certain surgical procedures and you would say that it does not necessarily take twice as much graduate training or twice as much skill or twice as much physical endurance. That is a pretty large magnitude.

Dr. ROPER. You are asking can I explain the disparity in those fees and I cannot. No.

Mr. LEVIN. Mr. Chairman?

Chairman STARK. Please.

Mr. LEVIN. Do you think the per-hour operating room figure is one useful indicator? I am guessing there will be some attack on that.

Dr. ROPER. Oh, I am sure there will be.

Mr. LEVIN. So anticipate the criticism of it. One attack will be that it is less per hour because the procedure is much longer and part of it is routine and part of it is not. So if you would, give us your critique in defense of using per-hour payments as one of the foundations. Did you use that, by the way, in calculating the reduction for cataract surgery?

Dr. ROPER. Let me just explain the cataract surgery study that I have alluded to a couple of times. What we did is compare two surgical procedures that ophthalmologists do. One where they insert an intraocular lens and one where they do not. We found that the surgery, the two procedures, take about the same length of time, but the insertion of the lens was priced 55 percent higher and we just said that does not make sense. We ought to be paying less for the higher priced procedure. And that was our proposal last year. To cut that 25 percent and we continue to urge that you legislate such a change.

Mr. LEVIN. That is the basis of it and not comparing different surgical procedures?

Dr. ROPER. It is hard enough to get the ophthalmologists to decide within their subspecialty how much things should be priced. What really gets difficult is comparing as the chairman was asking, ophthalmologists and cardio-vascular surgeons and it gets incredibly difficult to make the comparisons between the various surgical specialties and mine, pediatrics or internal medicine, or whatever.

Mr. LEVIN. So you did not use the comparisons that the chairman referred to, in reaching your conclusion?

Dr. ROPER. No, we did not. That whole process of reaching relative comparisons is what we are doing in our research study based at Harvard that is going to be another 2 or 3 years before it is done, and it is a very difficult task to come up with relative prices. I think, if I can take a minute more of your time, the task at hand is often called coming up with a relative value scale. Really, not many people are looking at relative value to patients. They are looking at relative resource costs stipulated in some fashion. I think, as a personal conviction, that we really ought to be looking at relative value. That is, is the patient going to benefit over the rest of their life more from this activity versus another. It is a very complex subject and one that I think is best left to the marketplace and not to regulators like myself.

Chairman STARK. One final question. In saving money, we have to allocate between capital and rebasing and medical education. Then options impact differently on different hospitals, or at least we presume that to be the case. And I am not sure there is going to be any symmetry between intercity hospitals and some of the smaller rural hospitals who, I suspect, are the two who have the most worthy cases for more money. Would you agree that they are the people who are suffering the most?

Dr. ROPER. Yes, they have the narrowest margins.

Chairman STARK. I beg your pardon?

Dr. ROPER. They have the narrowest margins at the present time.

Chairman STARK. Now, could you suggest to us an order of priorities if we are going to fine tune this. What would be the most efficient way, taking just the adjusters we have at our disposal, capital, reimbursement, disproportionate share, graduate medical education. Do we have any other special DRGs? I guess those would be the only things. If we wanted to help the intercity hospitals, where would we concentrate our efforts there? Of those items, what would be more beneficial for them?

Dr. ROPER. I understood that to be your desire in enacting the disproportionate share adjustment a couple of years ago to assist primarily innercity teaching hospitals. Beyond that, I think our proposal for capital payment has the potential for assisting particularly innercity hospitals that have not yet done major capital renovation. Everybody wins or loses. It depends on how high or low you set the PPS update figure.

Chairman STARK. No, what I am saying is let us suppose we were going to try and rifle-shot less of a cut or some increase, which ever you want to call it, toward the innercity hospitals, then I guess what you are saying, is that it is done through the disproportionate share adjustment and/or the capital adjustment. Which would you think is the better way to go about it?

Dr. ROPER. I suppose it would be allowing us to implement capital reforms so that those hospitals which have not yet invested can do so given the limited dollars at hand.

Chairman STARK. Do you think you could propose something?

Dr. ROPER. You mean a special fix for innercity hospitals?

Chairman STARK. Yes. I think as a practical matter, that is what we are going to try and do somewhere in our reconciliation procedure and it is always difficult when you are playing with averages to figure out how you are going to be most helpful.

Dr. ROPER. I understand your request. I guess my response has to be though, to the extent the goal is to hold harmless or benefit innercity hospitals and rural hospitals, we are approaching the moral equivalent of cost reimbursement, protecting everybody from losing.

Chairman STARK. I was going to ask you about rural hospitals next. Let us assume that I have given you a Hobson's choice as between capital and disproportionate share and you think that, if you are picking your own form of execution, you would pick capital. How about for the rural hospitals? Would that be the easiest to adjust there or would you push them toward disproportionate share or some other? If you wanted to help them specifically?

Dr. ROPER. I suppose if I were of a mind to additionally help rural hospitals, what I would do is have a higher PPS update for them than for other hospitals. In my earlier statement to Mr. Gradison, I explained my position on that point, though.

Chairman STARK. To summarize. If you had to pick, and you are not very wild about either one of the choices, would you suggest just a DRG adjustment for the rural hospitals?

Dr. ROPER. Yes.

Chairman STARK. But we might be more efficient than finding a capital reimbursement system that was different for the innercity hospitals.

Dr. ROPER. Of course, we believe that the proposals we put forward to you already are exactly what you ought to embrace.

Chairman STARK. I think they have. I think they do the job. I just think, as you mentioned in the question of the notch, there are certain political calculations in here that somehow you overlooked and we have to add those to your formula and I imagine that is going to give it a somewhat different appearance than what you have presented to us today. But as we begin to massage the figures and adjust them, we will look forward to your counsel and to working with you as we go on.

Dr. ROPER. Thank you.

Chairman STARK. Thank you very much.

Our next witness is Dr. Phil Lee, the Chairman of the Physician Payment Review Commission. He is accompanied by Paul Ginsburg, the Executive Director.

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL B. GINSBURG, PH.D., EXECUTIVE DIRECTOR; AND TERRY HAMMONS, M.D., DEPUTY DIRECTOR

Chairman STARK. Welcome back to the committee, Phil, and without objection, your prepared statement will appear in the record in its entirety and you can proceed to expand on it or summarize it.

Dr. LEE. Thank you very much, Mr. Chairman. I would like to ask also if Dr. Terry Hammons could join us at the witness table?

Chairman STARK. By all means.

Dr. LEE. Terry is a physician and is Deputy Director of the Commission.

Let me proceed right to the heart of the matter and submit for the record our full statement. The Commission considered, at the request of this subcommittee, several options that could be implemented quickly enough to reduce the projected increases in Medicare payments for physicians' services during fiscal year 1988. And as a result of our hearings on these issues, we considered an additional option that, after careful consideration, did not prove to be one that could feasibly be implemented during this coming fiscal year.

The primary options we considered were first, reducing the annual update of prevailing charges by the Medicare Economic Index, so-called MEI. The second was reducing prevailing charges for selected procedures judged to be overvalued relative to other procedures. The third was setting customary charges or charge limits for new physicians and the fourth, which was the one that proved not to be feasible for implementation, was reducing prevailing charges for services in geographic areas where charges exceed national or State averages by a substantial margin.

Let me just say a few words about the MEI proposal. The projected update to take effect on January 1, 1988 by the CBO for the MEI is 3.2 percent. This update could be reduced with primary care services, defined as office visits, nursing home visits and home visits, exempted from such reductions. The Commission's suggested definition of primary care services refers to service codes rather than physician's specialty. In other words, if the service is provided by a general surgeon, an internist, or a general practitioner, they would be included. The advantage of this option is that it would spread the burden of budget reductions over a large proportion of physicians serving Medicare beneficiaries but initiate movement towards a realignment of relative values for different services. In that regard, it is consistent with the Commission's recommendations in its report of March 1, that we move towards a national fee schedule based on a relative value schedule.

By protecting primary care services from the budget reduction, the option would change relative payments in a direction that we consider as very appropriate. The disadvantage is that it would not address other distortions in the patterns of relative payments. Let me move to the second option that was considered, reduce prevailing charges for selected procedures. The Commission believes that changes in relative payments for different types of services will be an important aspect of major reform in Medicare physician payment. Modest reductions in prevailing charges for procedures that appear to be most overvalued would be an interim change consistent with this expected long-term reform.

The Commission developed a method for identifying procedures that appear most likely to be overvalued in the Medicare program. The Commission, in doing this, compared current relative payments by Medicare to a series of other relative value scales that have some of the attributes of the relative value scale that we think will be the appropriate one to develop in the long term. This would be partially based on resource costs, reflect market considerations, and have a substantial input from physicians. That was the characteristic of some of these RVS's that we used for comparison purposes and are noted on pages 4 and 5 of the written testimony.

And in the appendix, we give a detailed analysis which compared relative values for 36 procedures. The procedures most likely to be overvalued have Medicare relative values that are consistently higher than in each of the other RVSs and are substantially higher than in most. And those at the top of the list, roughly the first nine, are the most likely to be overvalued.

The Commission is aware that prevailing charges for these procedures are lower in some localities than in others. In order to avoid reducing charges for physicians in localities that already have relatively low charges for these procedures, the Commission would recommend that any reduction in prevailing charges not apply where prevailing charges are less than 75 percent of the national mean for the procedure. Since the option affects only prevailing charge screens, physicians whose charges are relatively low for the locality, would not thus be affected.

The major advantage of this option is that it takes a step in the direction in the long-term reform. The principal disadvantage of this option is that it would make changes with the benefit of less data and input from physicians than will be available in the development of the relative value scale as part of the comprehensive reform of the Medicare physician payment plan.

In recent testimony before the Commission, representatives of several physician groups criticized the process that we utilized to identify overvalued procedures, and particularly criticized the use of Medicare data from only four States rather than national data. They also suggested that relative payments from a Canadian province are not appropriate for comparison with Medicare and that the results of the Hsiao study are subject to some error. The Commission carefully evaluated these criticisms. It concluded that on balance, this analysis is sufficient to support modest reductions in prevailing charges for a limited number of procedures.

Let me just say a word about customary charge limits for new physicians. Under current law, new physicians and others without historical profiles for a procedure, are initially given a customary charge for a procedure equal to the 50th percentile of customary charges in a locality. Whereas this was initially substantially below the prevailing screen. after years of constraints on prevailings, this level is close to the applicable prevailing screen in many cases. Thus, a new physician can often be paid as much as an established physician. The administration had proposed, although it was not included in today's testimony by Dr. Roper, limiting customary charges for new physicians to 80 percent of the prevailing charge. The physicians who commented on this to the Commission did not favor this approach, although I should say that none of them were new physicians. Also, as far as the Commission was concerned, this option was not consistent with long-term reforms and it would further complicate the administrative complexities with respect to the program.

Let me then say a word about reducing prevailing charges in geographic areas with highest charges. Given the extensive geographic variation in Medicare payments, it does not appear to be fully explained by variations in costs of practice. Budget targets could be met by reducing prevailing charge screens in areas with relatively high charges. A number of physician groups have suggested such

an approach as preferable to other options. We examined this option in some detail. There are several problems, one that relates to coding across carriers. There is not uniformity. A second relates to the limitation in data available to analyze proposals in this area. Because of these and other technical problems, we do not believe that this is a proposal that can be implemented during the fiscal year 1988, although we find it a very appealing area and is one where we will be working with Health Care Financing Administration to attempt to come up with some options in this area.

One proposal was made to the Commission that this be done on a State-by-State basis or carrier basis. In looking at that, we find that 17 States, regardless of where they would come out, would not be affected by this, those that have a single carrier. For those with multiple areas that are below the national averages, like Nebraska, Kansas, and Iowa, there would be reductions in the communities where charges are high relative to other communities in the State, but where they might be low relative to national averages of charges. So we did not feel that that was an equitable approach.

There were other options that we considered. One of these was coding, an area that we will be spending a good deal of time during the coming year to try to improve the situation.

The reforms that we think are most consistent with the long-term objectives as established by the Commission, if budgetary reductions under part B are necessary, are MEI reductions with the exemption of primary care services as we had defined them, and prevailing charge reductions for overvalued procedures. We did not think that the new physician option or the geographic variation were options that should be considered.

We looked at two other areas, one of which we had made a recommendation in our first report—incentive payments for primary care physicians in underserved areas. In the prepared statement, we detail the approach that could be taken to this area. Suffice it to say that we would use the Public Health Service determined health manpower shortage areas to determine those areas and depending on whether you picked all the areas or relatively few with the greatest need, the incentive payments could range from $10 million to up to $50 million.

[The following was subsequently received:]

As a result of further analysis, we now believe that the cost would range from a negligible amount to $20 million.

Dr. LEE. There are some unresolved issues. For example, should the payments be made only on assigned claims? Finally, with respect to radiologists, anesthesiologists, and pathologists, this was an area that the Commission examined quite carefully. We did not find evidence at this time to support a payment for hospital-based physicians on the basis of DRG's. Nevertheless, there are serious problems in this area, and one that is of great concern to the Commission is the exclusive contracts that are provided to these physician groups and what that does to beneficiary choice, or for the choice that physicians have in selecting say, a radiologist, for a particular patient who is hospitalized.

There are other problems that relate to volume. There are other problems that relate to price. These issues will be examined in

greater detail by the Commission, but we did not feel that the RAP DRG proposal, as it has been called, was an appropriate approach to this particular set of problems. In conclusion, Mr. Chairman, we appreciate the opportunity to provide the Commission's advice on how to deal with the short-term issues that you will face in the next few weeks. We feel that opportunities exist to discharge this budget responsibility in ways that move policy in the direction of long-term reform. The Commission looks forward to further work that will help the Congress achieve a comprehensive, long-term reform in Medicare physician payment. Thank you.

[The statement of Philip R. Lee, M.D. follows:]

Statement of the

Physician Payment Review Commission

Mr. Chairman and members of the Health Subcommittee, I came before you on March 3 of this year to brief you on the Physician Payment Review Commission's first annual report to Congress. The report outlined the nature of the problems in the current system of paying physicians for services delivered to Medicare beneficiaries, enunciated goals for physician payment policy, and a suggested a strategy for long-range reforms. The report also noted the likelihood of short-term policy changes and stressed the importance of their being consistent with long-term directions.

Consequently, when the Commission received requests from this committee and the Committee on Energy and Commerce for advice on how to meet budget objectives for fiscal years 1988-1990, it regarded the task not as a distraction from its long-term mission but as an opportunity to suggest first steps. In particular, the Commission sought to develop short-term options that would move the pattern of relative payments in the direction of greater rationality, while continuing to protect beneficiaries and avoiding making the program more difficult to administer and to understand. After I discuss budget options, I will describe to you the work that the Commission has done on its previous recommendation for an incentive payment for primary care services delivered in underserved areas and its thoughts on the issue of payment for the services of radiologists, anesthesiologists, and pathologists.

BUDGET OPTIONS

As part of the process for evaluating short-term policy alternatives to achieve budget savings, the Commission identified three options for consideration and invited groups representing physicians and beneficiaries to present their views on these and other possible options at a public hearing on May 27, 1987. Twelve groups participated in the hearing and seven additional groups submitted written comments. From this process we obtained suggestions for improvements in the options and some additional options. We also gained a better appreciation of the difficulties of satisfying the diverse interests when reductions from projected outlay increases are called for, something members of Congress are very familiar with.

OPTIONS FOR MEETING BUDGET TARGETS

The Commission considered a number of options that could be implemented quickly enough to reduce the projected increase in Medicare payments for physicians' services during fiscal year 1988. They include:

--reducing the annual update of prevailing charges by the Medicare Economic Index (MEI);
--reducing prevailing charges for selected procedures judged to be overvalued relative to other procedures;
--setting lower customary charge limits for "new" physicians;
--reducing prevailing charges for services in geographic areas where charges exceed national or state averages by a substantial margin.

Reduce Update of Prevailing Charge Screens by MEI

Since the mid-1970s, increases in prevailing charges have been limited by the MEI, which measures increases in practice costs. The update to take effect on January 1, 1988 is projected by CBO to be 3.6 percent. This update could be reduced, with primary care services, defined as office visits, nursing home visits, and home visit, exempted from such reduction. The Commission's suggested definition of primary care services refers to service codes rather than physician specialty.

The advantage of this option is that it would spread the burden of budget reduction over a large portion of physicians serving Medicare beneficiaries, but initiate movement towards a realignment of relative values for different services. Reducing outlays through changes in the MEI would apply to a broad range of procedures--representing 87 percent of Medicare physician payments. By applying only to charges not constrained by the MEI, it would not affect those services for which prevailing charges have not increased rapidly over time and those physicians whose charges are low relative to others in their locality. It would not add administrative complexity to the program.

By protecting primary care services from this budget reduction, the option would change relative payments in a direction that the Commission advocates for long-range reform. The Commission has been concerned that physicians are paid less well for primary care services than for other services, and that this distortion limits beneficiary access to these crucial services and is unfair to those physicians providing such services. Indeed, the Commission has received numerous reports from physicians indicating that Medicare payments for office visits barely cover overhead costs.

The disadvantage of this option is that it would not address other distortions in the patterns of relative payments. Outside of primary care, there are distortions in relative payments among different services and among geographic areas. The MEI reduction would affect procedures and areas that have relatively low payments as well as those with high payments. Physicians with low charges relative to others in their locality would not be affected, however.

Reduce Prevailing Charges for Selected Procedures

The Commission believes that changes in relative payments for different types of services will be an important aspect of major reform in Medicare physician payment. Modest reductions in prevailing charges for procedures that appear to be most overvalued would be an interim change consistent with the expected direction of major reform.

The Commission has developed a method to identify procedures that appear most likely to be overvalued by Medicare. The method compares current relative payments by Medicare to a series of other relative value scales that have some of the attributes of the relative value scale that the Commission envisions as a part of long-term payment reform. The ultimate relative value scale is likely to be at least partially based on resource costs, reflect market considerations, and have substantial input from physicians. This input would reflect both technical knowledge, such as the difficulty of various procedures, and considerations of equity among physicians.

The Commission has reviewed five relative value scales that have been developed by methods that reflect these considerations. They range from a resource-based scale developed by Professor William Hsiao using methods similar to his current study for HCFA, to the relative value scale negotiated over the past 17 years within the Ontario (Canada) Medical Association, to scales in use by two large insurers and a large multispecialty group practice, all of which were developed with substantial input from panels of physicians.[1]

The Appendix gives the results comparing relative values for 36 procedures. The procedures most likely to be overvalued have Medicare relative values that are consistently higher than in each of the other RVSs, and substantially higher in most. Those at the top of the list--roughly the first nine--are the most likely to be overvalued.

Within a few weeks, additional Medicare data should become available that would allow this analysis to be extended. These data will provide Medicare relative values based on data from across the United States, and will support analysis to determine whether additional procedures are overvalued by Medicare.

The Commission is aware that prevailing charges for these procedures are lower in some localities than in others. In order to avoid reducing charges for physicians in localities that already have relatively low charges for these procedures, the Commission would recommend that any reduction in prevailing charges not apply where prevailing charges are less than 75 percent of the national mean for the procedure. Since the option affects only prevailing charge screens, physicians whose charges are relatively low for the locality would not be affected.

If prevailing charges were reduced for one or more of these procedures, balance billing of beneficiaries could increase. The Commission was divided on whether to recommend limits on balance billing for such procedures.

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[1] Some have argued that a relative value scale from outside the United States is less appropriate for comparison. The results of the analysis are not changed by omitting the Ontario relative value scale.

The major advantage of this option is that it takes a step in the direction of long-term reform. By targeting payment reduction to those procedures deemed likely candidates for reduction in the future, the benefits of reform could be realized sooner. Also, focusing cuts on procedures considered relatively overvalued entails lower short-term risks of reduction in access to care and of financial protection for beneficiaries.

The principle disadvantage of this option is that it would make changes with the benefit of less data and input from physicians than will be available in development of a relative value scale as part of comprehensive reform of Medicare physician payment. The risk is that a procedure's payment is reduced now but then must be increased when a fee schedule is developed and implemented. The magnitude of this risk would depend on the size of the reduction made.

In recent testimony before the Commission, representatives of several physician groups criticized this process of identifying overvalued procedures. In particular, they criticized the use of Medicare data from only four states rather than national data, and suggested that relative payments from a Canadian province are not appropriate for comparison with Medicare, and that the results of the Hsiao study are subject to error. Some were concerned that Medicare payment policy would be based on this work that is much less thorough than that in progress for comprehensive reform of Medicare relative payments.

The Commission has carefully evaluated these criticisms. It concluded that, on balance, this analysis is sufficient to support modest reductions in prevailing charges for a limited number of procedures. I would like to note, Mr. Chairman, that most of those testifying before the Commission stated that some procedures are overvalued by Medicare. Several said that although they were uncomfortable with the method for identifying overvalued procedures, that those indicated by the method were, in fact, overvalued.

Customary Charge Limits for New Physicians

Under current law, new physicians (and others without a historical profile for a procedure) are initially given a customary charge for a procedure equal to the 50th percentile of customary charges in a locality. Whereas this was initially substantially below the prevailing screen, after years of constraints on prevailings, this level is close to the applicable prevailing screen in many cases. Thus, new physicians can often be paid as much as many established physicians. The Administration has proposed limiting customary charges for new physicians to 80 percent of the prevailing charge.

The advantage of this option is that it attempts to meet an equity concern often voiced by physicians that young physicians are often compensated more highly than more experienced physicians. While it is doubtful that the Medicare reimbursement system has contributed to this, the impact of this option would change the pattern of relative payments. Nonetheless, physician groups that commented to the Commission did not express support for this option.

Moreover, the option would not appear to contribute to long-term reform. Whereas extensive discussion has been devoted to the issues of variation in payment by type of procedure, by specialty, by geographic area, and by patient type, few have advocated variation by level of experience of the physician. The limit on customary charges could be a major problem to many new physicians who would be paid as much as 20 percent less than under current law. Those with large debts and those choosing to practice in geographic areas with low charges or specialties with relatively low earnings such as primary care could be particulary affected. Indeed, the option could seriously discourage entry into primary care in underserved areas. While the Commission does not favor this option, it recommends exempting primary care services if it is pursued.

Reduce Prevailing Charges in Geographic Areas with Highest Charges

Given the extensive geographic variation in Medicare payments that does not appear to be fully explained by variation in costs of practice, budget targets could be met by reducing prevailing charge screens in areas with relatively high charges. A number of physician groups have suggested such an approach as preferable to other options to reduce expenditures.

Concentrating budget cuts on high-priced areas is most consistent with some physicians' concepts of equity and might pose less risk of reduced access to care than across-the-board alternatives. Like the overvalued procedures option, it would be consistent with the direction of long-term reform that the Commission has recommended.

However, a number of technical issues limit what can be done for fiscal year 1988. Most acknowledge the need to adjust for cost-of-practice differences before making geographic comparisons, but such an index is not yet available. Also, carrier coding practices vary, so that geographic comparisons are subject to error. Finally, with the exception of a limited number of procedures, HCFA does not have the data to calculate national or regional means.

These technical problems limit the potential for policies to reduce geographic variation in allowed charges. Their existence limits the number of procedures to which the policy can be applied and the degree of stringency. The combination severely limits the 1988 budget savings that could be achieved.

The Commission believes that with a year of work, much more significant steps could be taken to revise the pattern of geographic variation. Under Congressional mandate, HCFA has been developing a cost-of-practice index. The national Part B claims files are just becoming available and are reported to be substantially more reliable than previous files. HCFA has been gathering some data from carriers on coding practices and prevailing charges. We plan to urge HCFA to expand and accelerate these activities substantially, so that the technical ability to deal with geographic variation is not so limiting.

One physician group has suggested that these limitations could be circumvented by reducing prevailing charges for localities in a state that exceed the state mean by some percentage. This would avoid many of the technical obstacles to pursuing a national or regional approach. But this interim approach could reduce payments in some areas where payments would ultimately be increased as part of a long-term reform. In states like Iowa, Kansas, and Nebraska, for example, which have multiple localities but generally low charges, prevailings in their highest charge localities could be reduced despite being below the national average. The 17 states without multiple localities would not be affected by this approach, irrespective of the level of their charges. Furthermore, without very stringent limits, the budget reductions from this approach would be small.

Other Options

A number of other options have been suggested to the Commission and were considered by it. Many appear to have merit, but are not candidates for this year's budget process because they cannot be implemented rapidly enough, they require more analysis, or the judgment that is required to implement them properly leads budget analysts to decline to estimate their savings. An example is coding. The Commission's report recommended a number of improvements in coding, but they will take time to develop and implement and require substantial judgment, making them not amenable to estimating budget savings. Thus, the Commission is proceeding with its work, but cannot develop an "improve coding" option for the fiscal year 1988 budget process.

Recommendations

Of the budget reduction options considered, the Commission views the first two--MEI reduction exempting primary care services and prevailing charge reduction for overvalued procedures--to be the most appropriate for meeting 1988 budget reduction requirements. Both are consistent with long-range reform and are technically and administratively feasible. The Commission does not support the new physicians proposal because is not consistent with long-range reform and raises some administrative concerns. While the Commission strongly supports the concept of reducing geographic variation that is not explained by cost-of-practice differences, it believes that short-term changes are not feasible at this time but should be possible a year from now.[2]

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[2]Commissioner Jack Guildroy prefers the overvalued procedure option to the MEI option. Commissioner Oliver Beahrs does not support the overvalued procedure option.

INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES IN UNDERSERVED AREAS

In its first annual report, the Commission recommended that Medicare pay an increment beyond approved charges for primary care services delivered in designated underserved areas. The additional payments are to be financed by a reduction in the Medicare Economic Index (MEI) update factor applied to all prevailing charges. The major issues related to implementation of this recommendation concern identifying eligible underserved areas, how to structure the incentive payment, and whether it should apply to all claims or only to assigned claims.

The Commission considered several methodologies for designating underserved areas, including those currently used by the Public Health Service (PHS), and concluded that the most feasible approach was to use the existing Health Manpower Shortage Area (HMSA) designations. These are used by the PHS for the placement of National Health Service Corps personnel. The HMSA designations are preferable to the use of Medically Underserved Areas (MUA) because they are updated more frequently, are focused more on considerations more relevant to Medicare beneficiaries, and are divided into four categories of need, thus affording additional flexibility in targeting the program consistent with the availability of resources.

The technical complexity and associated costs of identifying physicians by practice location is greater for urban areas than for rural areas. Non-metropolitan HMSAs generally are whole counties or towns within counties while urban HMSAs often are groups of census tracts within large metropolitan areas. Two alternative implementation strategies are to limit program implementation to rural areas or to have a phased implementation plan that would add physicians practicing in urban HMSAs as the technical issues of matching designated areas with physician practice location are resolved.

The annual costs associated with the Commission's recommendation, using HMSAs to identify eligible physicians and paying an increment of 10 percent for office visits irrespective of physician specialty, are estimated to range from $10 million to $60 million, depending on how many HMSA categories of need are included in the program and decisions on the construction and applicability of the incentive payment. Costs for FY1988 would be much lower, depending upon the number of months that the program is in effect.

The Commission has identified some other decisions that need to be made. The incentive payment could be in the form of either an increment to the allowable charge or an increase in the prevailing charge screen. The incentive could be limited to assigned claims or applied to all claims. Resolution of these issues will depend on administrative considerations, whether physicians whose charges are not constrained by Medicare screens should receive the incentive payment, the level of resources available, and other considerations.

PAYMENT OF RADIOLOGISTS, ANESTHESIOLOGISTS, AND PATHOLOGISTS (RAPs)

Considerable attention has been focused on reforming payment for services of RAPs to Medicare beneficiaries. Many have been concerned that both the volume and price of these services are excessive. There may be substantial inappropriate utilization of services provided by RAPs, both inpatient and outpatient. Concerns about price reflect the apparent absence of market forces to constrain them. Many hospitals have exclusive contracts with groups of RAPs, affording neither the patient nor his or her attending physician an opportunity to shop for a lower price. Furthermore, patients are rarely consulted about the choice of a RAP physician, yet are at risk for substantial balance bills. Medicare beneficiaries' balance bills may be particularly large for the services of anesthesiologists, since their charges are often well above the Medicare prevailing charge, and their rates of assignment and participation are among the lowest of all specialties.

The Administration has proposed to pay for inpatient RAP services on the basis of DRGs. DRG payment would allow control over expenditures for these services, and if the payment were made to the hospital, would protect beneficiaries from balance bills.

While the Commission is very concerned about payment for RAP services, it does not believe that paying for these services through DRGs is the most effective way to address these concerns. DRG payment would place RAP physicians at risk for inappropriate utilization of these services, but most inpatient utilization of these services is determined by attending physicians, not by RAPs. All payments for inpatient laboratory tests, including those for physicians, are already paid through DRGs under part A. Much of the inappropriate utilization of RAP services appears to be in outpatient settings, and RAP-DRGs would not address this.

The appropriateness of prices for these services can be addressed through fee schedules for these services. Finally, considerable work would be required to implement RAP-DRGs. The questionable advantages they promise may not justify this use of large amounts of scarce resources within the Department of Health and Human Services.

However, I would like to emphasize that the Commission recognizes the problems with payment for RAP services. The Commission is particularly concerned about the effects of exclusive contracting arrangements between hospitals and physicians--not just for RAPs, but also for others such as emergency physicians and cardiologists who interpret EKGs. We will examine closely the effects these arrangements have on the beneficiary's ability to choose a physician who will take assignment, and the implications for Medicare assignment policy for these services.

To summarize, the Commission intends to look very closely at the payment for services of RAPs and other hospital-based physicians, but we believe that these problems can best be addressed through modification of fee-for-service payment for these services rather than RAP-DRGs.

CONCLUSION

In conclusion, I appreciate the opportunity to provide the Commission's advice on how to deal with the short-term issues that you will be facing in the next few weeks. We feel that opportunities exist to discharge this year's budget responsibilities in ways that move policy in the direction of long-term reform. The Commission looks forward to further work that will help the Congress achieve a comprehensive long-term reform of Medicare physician payment.

APPENDIX

To assess whether a procedure is "overvalued" by Medicare relative to other procedures, Medicare relative values for 31 procedures were compared with relative values from several other sources. This Appendix describes the methods used, including selection of procedures for study, selection of relative value scales for comparison, the source of the data used to compute Medicare relative values, and the criteria for selection of "overvalued" procedures. Possible extensions of the analysis are described.

SELECTION OF PROCEDURES TO STUDY. The comparison is restricted to those procedures for which data on Medicare relative charges are available. At the present time, the only data of good quality available for Medicare relative values is that developed by Mitchell and Stason[1] for 31 procedures.[2] These procedures were selected by Mitchell and Stason on the basis of their inclusion in the 1985 Hsiao study[3], and data for Medicare charges were reliable. Mitchell and Stason included many procedures that account for relatively large amounts of Medicare expenditures.

The list does not include any of the procedures thought most likely to be undervalued by Medicare such as office and home visits. It is more difficult to make accurate comparisons among payments for visits.

The Commission staff has arranged for additional Medicare data in order to confirm this initial analysis with national data for Medicare allowed charges, and to extend the list of procedures examined. With additional data, relative payments for both related procedures (other members of "families" of procedures already studied, such as additional coronary artery bypass surgery procedures) and unrelated procedures, such as other types of surgical and medical procedures, can be analyzed.

SELECTION OF RELATIVE VALUE SCALES FOR COMPARISON. We sought to compare Medicare relative values to existing relative value scales (RVSs) that have some of the attributes of the relative value scale that the Commission envisions as a part of long-term payment reform. This eventual RVS is expected to be based in part on resource costs, to reflect market conditions, and will have substantial input from physicians. The RVSs chosen for comparison are not based entirely on charges, and each was developed with substantial input of expert opinion of physicians and others as to appropriate relative payment for procedures.

The five RVSs are referred to here by the abbreviations used in the attached table. Several were obtained under an agreement of confidentiality. "INS 1 RVS" and "INS 2 RVS" are based on schedules of maximum payments used by two large insurers. Neither is simply a reflection of current or past charges. Each was developed by the insurer with expert physician input as to appropriate relative payment levels for procedures based on factors such as relative time, effort, difficulty, skill required. Each schedule has been used to set maximum payments for physician services for several years. "GRP 1 RVS" is based on a schedule of maximum payments developed by physicians in a large group practice. It has also been used for several years by this physician group for fee-for-service reimbursement under negotiated contracts with a number of insurers. It has also been adopted by other physician groups.

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[1] J.B. Mitchell and W.B. Stason, What Should Medicare Pay for Surgical Procedures? Report to the Health Care Financing Administration under Grant No. 18-C-98758/1-01 (Center for Health Economics Research, Needham, MA: June 1986)

[2] There are 36 procedures in the Table. Pacemaker insertion and ureterolithotomy are each divided into three procedures, and we added appendectomy to the list.

[3] W. Hsiao, P. Braun et al, Final Report: Resource Based Relative Values of Selected Medical and Surgical Procedures in Massachusetts, Department of Health Policy and Management, Harvard School of Public Health (Boston, MA: December 1985)

The "ONTARIO RVS" is based on the current schedule of fees developed by the physicians of the Ontario Medical Association (OMA) and is used for payment of physician services in Ontario. The fee schedule is determined through negotiation among the physicians in the OMA.[4]

The "HSIAO RVS" is based on the 1985 Hsiao-Braun study referenced earlier. The method used in this study was similar to his present study in cooperation with the American Medical Association and a number of specialty societies: relative values were assigned to physician services on the basis of physicians' judgment of relative resource costs including time and effort, skill, risk, and judgment required. Dr. Hsiao has stated that he has confidence in the results of the study, though the error for an individual value may be as high as 25 percent.

The comparison will be extended to additional RVSs if appropriate RVSs become available. Well-known RVSs such as the California RVS and the Florida RVS have not been used. The relative values in the 1986 Florida RVS are simply the medians of charges submitted to Blue Shield of Florida, so are based entirely on past physicians' charges. The most recent California RVS is about 15 years old.

SOURCE OF MEDICARE RELATIVE VALUE. The relative values for Medicare were based on average allowed charges in four states (Alabama, Wisconsin, Washington, Connecticut) in 1984 as calculated by Mitchell and Stason. The data used were a 100% sample of Medicare claims in those four states; the data were first "cleaned" by Mitchell to eliminate duplicate and denied claims. The four states from which the data were gathered were selected to represent four regions of the country. The data base includes charges of both urban and rural physicians. Since the carriers from which the data were obtained had collected it in HCPCS (CPT4 for the physician services compared here), errors from incorrect translation of codes into HCPCS/CPT4 were avoided.

The quality of this data is superior to other available sources such as average allowed charges from the 1984 BMAD 1% provider file or the 1984 BMAD procedure file. Average allowed charges from the 1985 BMAD beneficiary file may soon be available; this would provide reliable average allowed charges for several hundred procedures, based on nationwide data. As noted above, it would allow additional procedures to be compared.

There are several choices for <u>which</u> Medicare charges are used for Medicare relative values, including average allowed amounts (average allowed charges), average submitted charges, and prevailing charges. Since prevailing charges vary by location and specialty, one would have to select <u>which</u> prevailing charges to use, or to average them in some way. We do not have the data to do this. As an alternative, we chose to use average allowed amounts, which reflect what Medicare actually pays physicians. Though each number represents an average over all specialists submitting charges for each procedure, the bulk of claims submitted for most of the procedures included in this study are from one or a few specialties.

CHOICE OF INDEX PROCEDURES. In order to compare relative values in different RVSs, the several scales must be "linked" by setting one procedure (or a combination of procedures) to the same relative value in all scales. The usual choice for this "linking" or index procedures is a common procedure with a stable technology and stable relative value such as cholecystectomy, inguinal hernia repair, or appendectomy. The comparison here used a composite of these three procedures, each weighted by its importance in Medicare. The weights are approximately 45% for cholecystectomy, 50% for hernia, and 5% for appendectomy, reflecting the relative expenditures for these services in 1984.

The use of a composite index procedure minimizes any possible influence of a "quirk" that would affect the value for a single index procedure in any of the relative value scales.

CRITERIA FOR SELECTION OF "OVERVALUED" PROCEDURES. A procedure is considered overvalued if its relative value under Medicare is consistently higher than in the other RVSs, and substantially higher than in most of them.

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[4] Several physician groups have testified that the Ontario fee schedule is not appropriate for comparison in this study because it is not used in the United States. If it were excluded from the comparison, the results could not change significantly.

The procedures that have the highest probability of being overvalued are at the top of the attached table titled "COMPARISON OF RELATIVE VALUES." The first nine appear to be most likely to meet the criteria for overvalued procedures.

GENERALIZATION FROM INDIVIDUAL PROCEDURES TO FAMILIES OF PROCEDURES. If one procedure is found to have a Medicare relative value that is high (or low) compared to other RVSs, can this result be generalized to similar procedures? For instance, if the Medicare relative value for coronary artery bypass graft (CABG) surgery for three arteries is higher than its value in other RVSs, does this imply that the same relationship would be found for other CABG procedures? Though it seems likely that it would, the question cannot be answered confidently without additional data (on Medicare relative values) to make directly the comparisons for each member of the family. The additional data is expected to be available soon.

In the particular case of the procedure for lumbar laminectomy, the individual procedure compared (code 62297) is a "wastebasket" procedure that should seldom be used. It is only the seventh most frequently coded laminectomy procedure in 1984 Medicare claims. Since this procedure is not representative of other laminectomy procedures, its status should not be generalized to other members of the laminectomy "family."

NOTES TO TABLE TITLED "COMPARISON OF RELATIVE VALUES"

The order of procedures in the table is based on the results of comparing the Medicare relative values with relative values in the other five scales. Procedures listed at the top of the table have Medicare relative values that are most consistently greater than relative values in the other RVSs. By the criteria used in the study, they are the procedures most likely to be overvalued by Medicare. About nine procedures appear to be have relative values for Medicare that are consistently higher than in the other relative value scales.

The index procedure set to 1.000 in each RVS is a composite index constructed from the relative values for appendectomy (5%), cholecystectomy (45%), and inguinal hernia repair (50%). The weights were derived from the fraction of Medicare expenditures accounted for by each of the three procedures.

The Hsiao-Braun study did not determine a relative value for "Lens Extraction w/ IOL." A relative value for the "Hsiao RVS" has been imputed to be 146% of the value for "Lens Extraction, intracapsular." This is the same ratio of relative values found in the Medicare RVS.

The Medicare relative values for the three cataract surgery procedures have been reduced by 8.5 percent to reflect the ten percent reduction in prevailing charges under the Omnibus Reconciliation Act of 1986. The "correct" reduction is not exactly known, but would be some fraction less than ten percent; we estimated 8.5 percent. The reduction in average allowed amounts is less than ten percent because some physicians' charges were below prevailing charges and were not reduced, and some prevailing charges were not reduced (they were beneath the floor of 75 percent of the national average).

TUR/medium bladder tumor: CPT-4 code 52235 is used for tumors 2 to 5 cms. in diameter. There is not an exact match of codes for Insurer 1's RVS. One code is used to pay for procedure with tumor sizes .5 to 3 cms., and another code is used for tumors over 3 cms.

Uterolithotomy: CPT-4 codes 50610, 50620, and 50630, refer to the upper one-third, middle one-third, and lower one-third of the ureter respectively. The relative values for Medicare and Hsiao have been weighted by utilization. Ontario has only two codes related to the upper two-thirds and the lower one-third. Insurer 1 uses only one code to cover all of the procedures.

Lumbar laminectomy: CPT-4 code 62297 could be matched to either of two codes for Insurer 1. One code for laminectomy (exploratory, negative for tumor) or a second code for laminectomy (for disc, lumbar, unilateral) may be used by physicians with some clarification. A staff person for this insurer said doctors would probably use the latter code, specifying that the procedure performed was exploratory in nature and did not include a disc. They would send a copy of the relevant report to substantiate their claim. To be conservative we used the higher relative value for the former code.

Permanent pacemaker insertion: CPT-4 codes 33206, 33207, 33208. The relative values have been weighted by utilization for these three procedure codes for Medicare and Hsiao. Insurer 1 recognizes only one code and does not distinguish whether the procedure performed was atrial, ventricular or AV sequential.

Coronary artery bypass graft for three arteries: CPT-4 code 33512. Ontario pays a small additional amount when the internal mammary artery is used. In such cases the relative value is increased by about seven percent.

Peripheral iridectomy for glaucoma: CPT-4 code 66625. Because of the uncertainty of the match of codes for Ontario, the procedure with the higher relative value was used. The other possible procedure code has a relative value about 15 percent lower.

Laser photocoagulation for diabetic retinopathy: CPT-4 code 67226 has been replaced by code 67228.

Extraction of lens, intracapsular: CPT-4 code 66920. Two relative values have been determined for Insurer 1 which correspond to the two codes they use to pay for this procedure depending on whether or not an iridectomy is also performed. If the iridectomy were performed, the relative value would be slightly higher.

Cataract extraction with intraocular lens implantation: CPT-4 code 66980 has been replaced by codes 66983 and 66984.

COMPARISON OF RELATIVE VALUES

PROCEDURE DESCRIPTION	CPT-4 CODES	MEDICARE RVS	INS 1 RVS	INS 2 RVS	GRP 1 RVS	ONTARIO RVS	MSIAQ RVS
CABG (3 vessel)	33512	6.431	4.543	3.760	4.021	3.892	4.893
Total hip replacement	27130	3.579	2.752	2.698	2.412	1.425	2.229
IOL insertion only	66985	1.507	0.969	1.106		0.827	0.944
Lens Extraction w/ IOL (SN)	66983,984	2.318	2.128	1.770	2.091	1.572	1.392
Lens extraction, intracapsular	66920	1.584	1.393	1.106	1.609	1.200	0.951
Suprapubic prostatectomy	55821	1.905	1.456	1.106	1.609	1.298	1.423
TURP	52601	1.777	1.456	1.106	1.609	1.266	1.284
Diagnostic D&C	58120	0.389	0.257	0.309	0.320	0.258	0.333
Carpal tunnel repair	64721	0.772	0.433	0.752	0.643	0.444	0.500
Lumbar laminectomy	62287	2.456	1.778	1.991		1.754	1.416
Mitral valve replacement	33430	4.740	4.075	3.539	3.056	2.612	4.525
Diagnostic colonoscopy	45360	0.488	0.339	0.271	0.450	0.319	0.507
Diagnostic laparoscopy	58980	0.635	0.396	0.530	0.643	0.346	
Periph.iridectomy/glaucoma (SN)	66625	0.984	0.774	0.774	0.965	0.696	0.514
Ureterolithotomy 1 (SN)	50610	1.619	1.359	1.106	1.529	1.059	1.451
Ureterolithotomy 2	50620	1.619	1.359	1.106	1.447		1.451
Ureterolithotomy 3	50630	1.619	1.359	1.106	1.609	1.355	1.451
Fesoral fracture/ open	27236	1.938	1.769	1.239	1.769	1.432	1.909
Permanent pacemaker insertion V	33207	1.494	1.562	1.150	1.447	0.905	1.032
Permanent pacemaker insertion A (SN)	33206	1.494	1.562	0.973	1.447	0.905	
Permanent pacemaker insertion A-V	33208	1.494	1.562	1.482	1.442	1.272	
TUR/medium bladder tumor (SN)	52235	1.053		0.739	0.801	1.228	0.722
Scleral buckling	67107	2.461	2.419	2.212	2.412	1.573	1.686
Total abdominal hysterectomy	58150	1.447	1.187	1.150	1.367	1.212	1.305
Tracheostomy	31600	0.505	0.586	0.332	0.434	0.439	0.576
Lung lobectomy	32480	2.505	2.437	1.770	2.091	2.667	2.887
Reduction of wrist fracture	25610	0.485	0.570	0.376	0.482	0.317	0.548
Laser photocoagulation (SN)	67228	0.876	1.168	0.885	0.965	0.516	0.544
Modified radical mastectomy	19240	1.537	1.563	1.283	1.287	1.414	1.777
Inguinal hernia repair	49505	0.816	0.791	0.973	0.724	0.792	0.680
Appendectomy	44950	0.755	0.781	0.681	0.804	0.705	0.695
Cholecystectomy	47600	1.235	1.270	1.062	1.335	1.256	1.395
Diagnostic cystourethroscopy	52000	0.153	0.117	0.195	0.160	0.199	0.174
Esophagogastrectomy	43120	3.030		3.650	2.252		4.171
Insert aortic balloon pump	33970	0.760	0.787	1.261	0.482	1.183	0.708
Cystectomy w/ urinary diversion	51590	2.973	3.241	2.331	3.529	3.513	5.989

SN = SEE NOTES

Chairman STARK. Thank you. Let me just kind of review a minute how you came up with some of these studies and also on this sheet that compares the relative values. Your Commission is made up of entirely of physicians?

Dr. LEE. No, sir. There are six physician members, I believe, and seven nonphysician members. We have three economists. There is a benefits manager, Mr. Wright from Caterpillar Tractor. There is a consumer representative, who was nominated by AARP but does not represent AARP, Jack Guildroy from New York. So that the physicians are not in the majority on the Commission.

Chairman STARK. Do you have physicians available either on staff or as consultants?

Dr. LEE. We have one senior physician, Dr. Terry Hammons, who was at the University of Iowa on the faculty who is the Deputy Director and also we, of course, consult with a number of physician groups with respect to the issues that are being addressed by the Commission.

Chairman STARK. Now, do you then take your recommendations or do you discuss them formally or informally with HCFA or do you pretty much come directly here?

Dr. LEE. Well, we are, of course, independent of HCFA. There is a considerable interchange with the HCFA staff and, as a matter of fact, this past week, the full Commission met with Secretary Bowen to discuss with him areas of cooperation, both at the policy level and at the staff level with the HCFA staff.

Chairman STARK. Did you get testimony or consultation from the various medical specialties involved in these so-called expensive procedures?

Dr. LEE. Yes, sir.

Chairman STARK. OK. And most people on your staff and on your Commission could understand what a diagnostic laparoscopy is?

Dr. LEE. Yes. A sigmoidoscopy or a colonoscopy, we had testimony on that specific procedure and I would say the majority of the members of the Commission understood that, and for those who did not, it was, in fact, explained at a Commission hearing.

Chairman STARK. What I am getting at is that the Chair of the subcommittee does not understand what their procedures are, and I just wanted to make sure that you were talking with people who did when you came up with your recommendations. Now, let me ask you what, in this situation, you have listed here on this comparison of relative values, the Medicare's relative values, the second column and I assume that there are two insurance companies, insurance company 1 and insurance company 2. Is that what INS 1 and INS 2 are?

Dr. LEE. That is correct, yes. Terry, you want to go over those?

Chairman STARK. Well, let me just go down further.

Dr. LEE. OK.

Chairman STARK. Then it is group 1 which would be a group practice?

Dr. LEE. That is correct.

Chairman STARK. Then, what they pay in Canada, which you say may or may not have much relevancy.

Dr. LEE. In one province in Canada, correct.

Chairman STARK. And then Hsiao is the Harvard study?

Dr. LEE. Correct. That is the RVS values that he came up in his earlier study. I want to emphasize that we are talking about relative values, not absolute payments.

Chairman STARK. OK. Now when an insurance company, either insurance company 1 or insurance company 2, uses this relative value, the first one up there is—what is a CABG 3 vessel?

Dr. LEE. A coronary artery bypass graft surgery, a three-vessel graft.

Chairman STARK. Now the insurance companies, if they have a 4.543, do they base how much they will pay for the surgeon on this relative value number?

Dr. LEE. For that particular company, that would be correct. They would have a dollar conversion factor that would then translate that into actual dollars, but that would be the relative value.

Chairman STARK. Do one of these two companies, without identifying it, cover a broad area, a State, or a huge metropolitan area?

Dr. LEE. They cover a wide, geographic area and I should say, Mr. Chairman, on these relative values, we used as the index procedures, if you will, cholecystectomy, appendectomy, and inguinal hernia, in combination, so that we would not have a single procedure that would be an index for relative comparisons.

Chairman STARK. I am just trying to get at something here, but I am probably beating around the barn too far. How do you suppose an insurance company like 1 or 2 arrived at that relative value and the amount they pay? Through negotiating with a group of doctors in that specialty? How would you guess that insurance company 1 or insurance company 2 arrive at their relative value?

Dr. LEE. Dr. Hammons worked on this particular methodology and I would like him to respond to that to give you the most factual answer.

Chairman STARK. Please.

Dr. LEE. Terry?

Dr. HAMMONS. In both cases, in both insurance company No. 1 and No. 2, there was considerable physician input into the determinations of the relative prices. They were not negotiated formally—as far as I know, they are not anywhere by the insurance company here, with their physicians. So they used expert physician input that was available to them. In each case, of course, they have used it to pay physicians, and that has worked. I has been accepted by the physicians.

Chairman STARK. Now, because it appears in many cases, or in most cases, that the Medicare scale is higher, is there a different procedure of negotiation or study that goes into the Medicare relative value?

Dr. LEE. The Medicare relative value is based on the customary, reasonable and prevailing system which was adopted by Medicare at the time it was enacted. Many of the other systems you might say were based on historical RVS', such as the one that had been developed in California or other States, and were not based on what the individual physician charged and what was the prevailing charge in the community, which is the method, basically, that Medicare used. So that Medicare did use in the main a somewhat different method for determining physician relative values.

Chairman STARK. Is there anybody else who uses the Medicare system, which I gather may be part of the problem in the distortion?

Mr. GINSBURG. Mr. Chairman, many private insurers use a similar approach to Medicare of basing payment on what the physician's charge is, and they screen it to see if it exceeds prevailing standards in the community, et cetera.

I understand that, actually, many years ago before Medicare, many insurers used fee schedules, but the innovation in health insurance at the time was to use this type of usual, customary, and prevailing system, and Medicare adopted it. Then many of the other insurance companies followed suit.

Now, we are seeing some insurance companies trying to move away from it, out of concern with the pattern of relative payments.

Chairman STARK. The recommendations that your Commission suggests could very well lead to increased out-of-pocket costs for the beneficiaries because, if we follow the recommendations of the administration and cut payments on these overpriced procedures, there is nothing to prevent the nonparticipating physicians from increasing the extra billing, is there?

Dr. LEE. Congress currently has a policy that they adopted when payments were reduced for cataract surgery. So Congress might decide to continue the policy with respect to other procedures that were considered overvalued relative to other procedures.

The Commission, because it has not had the time to carefully examine the participating physician program or issues related to assignment, could not reach agreement on that issue and, therefore, did not take a position with respect to what other policy should be adopted.

My own view is that one would assume that Congress would not change its current policies if it reduced payments for additional procedures.

Chairman STARK. Well, let me put it this way. If you take the nonparticipating, there is nothing to assume that this will reduce the cost; it may not increase it, but does it necessarily reduce the cost to beneficiaries?

Dr. LEE. Well, the only way it might reduce the cost would be by reducing the payment if they accepted that payment as payment in full.

Chairman STARK. That is what I am saying.

Dr. LEE. Yes.

Chairman STARK. Only those who take assignment or participate.

Dr. LEE. Correct.

Chairman STARK. Would there be any saving to the beneficiaries? There would be some savings to Medicare if we cut what we pay, but if the physician could still continue to have it who is extra billing, do the present rules on extra billing——

Dr. LEE. Well, it is my understanding with the maximum allowable actual charge restraints would apply to these particular procedures. That would be my interpretation, although I am not a hundred percent sure on that.

Chairman STARK. Would there be an automatic decrease just because——

Dr. LEE. No, no. That is right. No, there would not be a decrease. They would not automatically raise it, which they might otherwise do, but there would not be an automatic saving to the beneficiaries.

Chairman STARK. To the beneficiaries.

Dr. LEE. That is absolutely correct.

Chairman STARK. What I am basically saying is that except unless we legislate otherwise for the beneficiaries who would go to a participating physician, this cost savings will not necessarily benefit the beneficiaries. It will save the Federal budget, but it will not save anything for the beneficiaries unless they go to a participating physician.

Dr. LEE. Or a physician who is willing to accept assignment.

Chairman STARK. Right.

Dr. LEE. Yes.

Chairman STARK. OK.

Mr. GINSBURG. The only constraints on nonparticipating physicians, unless you had a balanced billing limit, would be the fact that, I believe under an OBRA 1986 provision, beneficiaries have to be given estimates of balance bills by nonparticipating physicians, and presumably those estimates would grow if the physicians did not lower their charges.

Chairman STARK. Does the Commission consider it likely that the physicians who do not participate or take assignment would reduce their fees if we were, in fact, to lower the Medicare payment for these?

Dr. LEE. There was really not any discussion of that particular question, so I, again, could not speak that the Commission had a position on that question. But it is clearly not likely.

Chairman STARK. OK. Mr. Gradison?

Mr. GRADISON. Thank you, Mr. Chairman.

Dr. Lee, you all are doing a great job in a very short period of time, and I want to express my personal appreciation for the contribution you already have made to our efforts to develop some public policy in this area.

I also want to thank you for this table in the back of your testimony. Now that it has been explained, I have a clearer idea what the numbers mean. But I am not sure that the Congress is well positioned to make the choices itself with regard to just which specialties, which procedures, to be more exact, should be targeted for payment reductions.

I will admit that there are plenty of issues that I vote on that I may not understand, but I usually can pronounce them. In this instance, I am not sure that I either understand them or can pronounce them.

In OBRA, we provide a process for the Secretary of Health and Human Services to determine which services are overpriced and to act on these matters. What do you think we ought to do? Should we pick and choose ourselves, or should we permit the Secretary to do it? And if we are going to permit the Secretary to do it, have we given him enough authority to enable him to make an intelligent decision based upon some criteria that are fair?

Dr. LEE. As we indicated in the report of March 1, the inherent reasonableness policy which was established last year was very complicated in terms of procedures for implementation. Perhaps as

a result of that, the Health Care Financing Administration has not, in fact, made—or the Secretary has not, in fact, made—recommendations under that authority, although in Dr. Roper's comments today it would suggest they are proposing one procedure to be reduced under that authority.

It was our view, the Commission's view, that an alternative approach should be used; and when we were asked by this committee for additional advice with respect to budgetary reductions, we looked for alternative methods that might be used as an alternative to the inherent reasonableness procedures. We came up with this alternative.

I think that it is clearly not ultimately desirable to have the Congress establishing what you pay for an individual procedure. That should really be done by the Health Care Financing Administration under policy guidelines established by the Congress. The fact is that in this area it has not been possible to get a satisfactory resolution, I believe, of the differences between the Congress and the Health Care Financing Administration, and that is the reason I think at this point, at least, we are in a somewhat of an impasse, and why we, then, developed this alternative methodology.

You could adopt this methodology, but then the Congressional Budget Office would not give you any estimates about reductions. They would say, well, you have to give us the particular procedure in order to give you the budget reduction estimates. But if you can live with that—except I think under the budget resolution you have to come up with specific reductions. In order to do that, it seemed to us you had to have a specific list.

Mr. GRADISON. I understand the way the budget process works, and you have explained it very well. I realize that many of our decisions are influenced by scorekeeping considerations. But this is one in which I find it very troublesome to continue down the road of picking out particular procedures. I am much more interested in seeing whether we could write more clearly a policy that could be administered by the Department, if indeed, that is what they are facing.

As I recall the way in which the policy was written last year in the conference, I really do not believe that we were trying to write an unadministrable policy. Maybe we put in factors which are difficult to quantify and, therefore, cannot be implemented in its present form.

Let me ask you this question, then: If we were to determine that we wanted these decisions to be made administratively rather than through legislation, could you assist us in the crafting of statements of congressional policy which, in your judgment, would be administrable and would be consistent with the policy directions towards which we ought to move?

Dr. LEE. Yes, we would be very glad to do that.

Mr. GRADISON. I appreciate that.

Dr. LEE. I think that makes more sense than doing it procedure by procedure.

Mr. GRADISON. Maybe our focus should be on writing this properly and talking to CBO about the scorekeeping rather than letting the scorekeeping drive us.

Dr. LEE. We absolutely agree with that. For budgetary considerations to drive policy is just turning the coin on its head, and hopefully it can be the other direction.

Mr. GINSBURG. Certainly from conversations I have had with people in the administration, they seem to regard what they call inherent reasonableness as one of the more desirable methods of meeting budget objectives. The sense we have gotten is that they felt that they would not be successful in bringing specific procedures through the regulatory process because of the burden on them to show that they were studying each issue extensively, and the ability of groups to contest their process.

I guess it is noteworthy that they came to you and suggested cataract surgery as their proposal in this area, rather than reduce its payment through their regulatory process.

Mr. GRADISON. That is a sorry admission if the Department is afraid that they will be subject to criticism because however hard they try to be fair, they would have to face the charge that they are not fair. I do not know what we are being asked to do here, except I am troubled to be called upon to make that decision.

Dr. Lee, Chairman Stark and I recently wrote to you concerning the volume issue.

Dr. LEE. Yes.

Mr. GRADISON. I appreciate that you mentioned already in your earlier statement that it is one of the issues you are working on. I have trouble understanding how the adoption of a relative value scale, however well conceived, would deal with the volume issue. Could you lead me through this a little bit?

Dr. LEE. Well, the one thing that that might do is to change the signals in the present system that we think distort utilization. Again, I will speak more from a personal standpoint than from the Commission, because if the Commission has not discussed something I do not want to just represent it as the Commission's view.

But if, with the existing payment policies, we are finding that procedural services—endoscopies, surgical procedures, medical procedures such as electrocardiogram, laboratory tests—those procedures appear to be overused as opposed to an office visit, a time-related service unassociated with the procedure, those we think are related to these signals, economic signals that reward physicians, it is not surprising that they respond to those economic signals.

There is a second problem, and that has to do with the coding. On this question of the sigmoidoscopy and the colonoscopy, we were informed at a Commission hearing that physicians had been advised by carriers to up-code from a sigmoidoscopy—which is paid a relatively modest amount—to a colonoscopy—which is a more complex procedure and gets a much higher level of payment. That kind of up-coding is part of this volume problem.

A third problem is the complexity of the care itself. We are seeing a lot of patients who are now cared for in an ambulatory setting who used to be cared for in the hospital. So that under part B, expenditures are going up much more rapidly, but part of that is because of the shift of locus of care of people with complex problems out of the hospital, more things done outside the hospital. We have much more effective means in the hospital to look at utilization, to carry out utilization review and quality controls than we do

in even the hospital outpatient setting, the emergency room, or in the physician's office. We simply must develop systems for utilization review that will help us address the volume problem in these other settings.

Certain organizations working with major corporations have, in fact, developed you might say standard protocols that they use for case management of high cost cases. It is those cases, it is the relatively small number, that have very high costs that you really want to look at primarily.

For example, a patient with gastric cancer or lung cancer or colon cancer, where they have had surgery, where they get radiation therapy, and they may also get chemotherapy, and the costs can be very high. You want to make sure that that is an appropriate mix of services.

It is in the high cost cases where I think substantial savings can be made through appropriate—what some people call case management; other people would call utilization review. That is an area we certainly will be looking at.

Mr. GRADISON. Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. If the gentleman would yield. Just to review, I think that Mr. Gradison, Dr. Lee and I would agree that a more efficient way to handle this would be to have HCFA suggest these reductions rather than have a group of laymen such as ourselves, people unfamiliar with medical terminology and technology, making these decisions. But I believe, as I read your testimony and HCFA's testimony, that if we were doing this in a different manner, we would probably come to pretty much the same conclusions this year relative to a few of these high-priced procedures.

Although this may not be the best system for now, and although it would be far preferable for you all to deal with people much more technically competent than this subcommittee, that even the people who criticize the methodology before your Commission agreed that these particular procedures were, in fact, overpriced. And it also happens to be the only way we can get any budget savings if we are going to reduce them.

Mr. PICKLE. Now, Mr. Chairman, that statement was made by just a few people. That was not a committee recommendation that they are all overpriced. That was just raised by a few people on the committee. I think you discolor the issue if you talk about everybody.

Chairman STARK. I would be glad to repeat my statement.

Of the witnesses who testified before the Commission, it is my understanding that many of those who disagreed with the methodology the Commission was using did, in fact, agree that the results were correct and that these procedures were, in fact, overpriced. Is that a fair analysis of your testimony, Doctor?

Dr. LEE. A number of the individuals who spoke said, indeed, there were overpriced procedures, and they thought even though they did not agree with the methodology, if they used another approach they would probably come up with a similar list. Now, that was not uniform, and it was not necessarily representative of the organizations that they represent. But these were individuals who testified who made such statements.

Chairman STARK. So would it be your testimony that there might be some better procedures, and it might be better for HCFA to be setting these rates rather than a congressional committee; but given the confines of our ability to get budget savings the procedures we are talking about today are, in fact, overpriced, and ought to be reduced by the amounts suggested, whether or not the methodology for getting there is the best or not. This is something that in your considered opinion we should do at this point in time?

Dr. LEE. Our judgment was that this methodology is as good as there is available, that if you choose to make reductions, this list that we provided is an appropriate list based on the judgment of the commissioners as well as based on the results that came out of this analysis.

We do hope to be able in the next several weeks, if that time is available, to extend the data, to look at a larger number of procedures, and look at a much larger number of States in terms of the Medicare data. That was one of the criticisms, the limited number of States that were included in that data base.

Chairman STARK. I thank you. Mr. Levin?

Mr. LEVIN. We are conferring up here.

You stopped at nine. Why? Show me on the chart why nine?

Dr. LEE. Terry, do you want to speak to that question? We looked at 36 procedures, and 9 appeared to be, relative to these index procedures, overpriced. A number of them did not appear to be overpriced, and that was the reason we came up with the nine.

Is that not correct, Terry?

Mr. LEVIN. In terms of procedures being overpriced, does this list go from top to bottom?

Dr. HAMMONS. Roughly, it does, within the limits of the methodology.

Mr. LEVIN. So it is the comparison with the ninth one, right, which is carpal tunnel repair?

Dr. HAMMONS. Yes.

Mr. LEVIN. So you compare the 0.772, which is Medicare with what—is it with the average of all of these? Would you go over that one?

Dr. LEE. Terry, do you want to describe that methodology just a little bit.

Dr. HAMMONS. It is not strictly the average. It is, rather, whether when you look at each row, the set of numbers going across the page from left to right, the Medicare relative value is generally or is consistently greater than the relative values under the other scales. It is not intended to be an arithmetic manipulation that says it is exactly point something. It is a general impression.

Mr. LEVIN. A general impression.

Dr. HAMMONS. Yes, of consistency, particularly.

Mr. LEVIN. And in that respect, you stopped at nine because after that there is not the same consistency?

Dr. LEE. Correct. If you look at, say, down at lobectomy, you can see that in some, Medicare is higher relative to these index procedures, and for some it is lower. So that the top nine were consistent across all of the other comparisons.

Mr. LEVIN. Take the tenth one now, where——

Dr. HAMMONS. May I speak to the 10th one, please?

Mr. LEVIN [continuing]. It is much higher than all the others, right?

Dr. LEE. It was pointed out to us—and Terry will talk to this—that this, in fact, is not an appropriate procedure to make comparisons because there are some technical differences there. Terry?

Mr. LEVIN. Well, take the 11th one. I am asking this only because we are going to have to vote on some cuts. I think we want to be reasonably assured of what we are doing. For the mitral valve replacement, the Medicare factor or RVS is higher than all the others, right?

Dr. HAMMONS. Right.

Mr. LEVIN. Why should not we proceed on that? There is consistency there, right?

Dr. HAMMONS. You could make that conclusion. I think what might give one pause is the last number in that row, the number under the Hsiao resource-based relative value scale is rather close.

Again, one has to make a somewhat subjective determination about how to weigh each of the relative value scales, and in this case we decided that we would not include that one because of the Hsiao relative value being so close to the Medicare relative value. One could reach a different conclusion.

Mr. LEVIN. OK. Now, most of these procedures, nine and above, are performed on relatively small numbers of Medicare beneficiaries, right? Would the hip replacement be second after the cataract procedures?

Dr. LEE. Go ahead, Terry, if you have the numbers.

Dr. HAMMONS. I do not.

Dr. LEE. Actually, hip replacement, coronary artery bypass graft, the suprapubic prostatectomy, the transurethral prostatectomy—all of those would be fairly common procedures on individuals over 65. We could provide you with the actual numbers or Health Care Financing Administration certainly could provide you with those numbers.

Mr. LEVIN. OK. Just one other question. We are going to have to get into this deeply. As others have said, your help is valuable.

With the RAP's, just tell me, because the question has arisen in other ways. It is maybe an unfair question—no, I think it is a fair question. It may be hard for you to answer.

What is the dynamics, the politics of the Commission? Does that have anything to do with your holding back on the administration's RAP proposal?

Dr. LEE. Not in my view. You know, we have nobody that could be, I think, considered to represent any of those specialties on the Commission. We heard a lot of testimony, and none of it was convincing. The testimony that was convincing was that this was not an appropriate approach to those three physician specialties.

A number of the pathology procedures, for example, are already under part A, as was pointed out to us, so that some of that concern is already being dealt with under previously established policies by the Congress. We were not convinced with the information that was provided us that using a DRG policy was either—we thought it was risky in terms of the potential impact on beneficiaries because we did not get evidence that would assure us that

they would not be adequately protected if those physician groups were included in the hospital DRG or in a DRG payment.

Mr. LEVIN. So what you are suggesting is that the issue could be addressed through fee schedules for these services?

Dr. LEE. Well, we think both fee schedules and also we need to look at the contracts. One policy that could be considered is if the hospitals said any physician who has an exclusive contract with the hospital has to accept assignment for Medicare beneficiaries. Pathologists already, a very high percentage of them, accept assignment. A significant number of radiologists, a very low percentage of anesthesiologists do. That would be one possible consideration.

Another would be that in those exclusive contracts the hospitals would have to have some concern about charges. As far as we can tell—we have not looked at this in detail at all—the hospitals have exerted very little control over charges of those physician groups who have an exclusive contract for services in that particular hospital.

There are some areas that need to be examined with respect to the exclusivity of these contracts, and what policies might be adopted that would be more equitable and more beneficial as far as the beneficiaries are concerned.

Mr. LEVIN. How do we get at that? By squeezing hospital reimbursement generally?

Dr. LEE. One would be under part A or under the policies which you establish. You would simply establish as policy that any contract that was let for exclusive services, that that contract would have to assure that the contractors would have to accept assignment.

Mr. LEVIN. One way to get at this is to mandate assignment in all such cases?

Dr. LEE. That would be one way to get at the price problem and the balanced billing of beneficiaries. It does not get at the volume problem. That we have to get at through PRO's, and I think there is considerable progress being made with respect to both the appropriateness reviews and the utilization reviews in general within the hospitals.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Well, I thank you.

When you were asked to make this study, you were asked to ascertain the values for purposes of budgetary consideration. You have just given us a laundry list of possible options. The charge you were given as a Commission, partly coming from this committee, was to identify for us some areas that we might cut to stay within the budget.

The question of participating or nonparticipating physicians has no part in your study, does it?

Dr. LEE. We have not examined that question, Mr. Pickle, sufficiently to comment as a commission. The number of policy changes that had been made by the Congress in the recent years with respect to participating physicians, we felt we would monitor that. We were not going to make additional recommendations, and we

have not further examined that issue. We intend to do that in the fall, but we have not done that to date.

Mr. PICKLE. That was not your charge, and you have not looked into it. The question of whether you are a participating or nonparticipating physician has nothing to do with the budget, really.

Dr. LEE. No, it does not. It affects——

Mr. PICKLE. I want to make that point. When you drag in the participating or nonparticipating physician, it really has no direct bearing on the budget. That is my point.

Dr. LEE. Correct.

Mr. PICKLE. All right. I am not going to ask you to go through this whole procedure again about relative value to determine which procedures were overpriced. Does the written copy of your testimony tell us the steps you went through to determine these values?

Dr. LEE. The appendix to the testimony describes in some detail the methodology.

Mr. PICKLE. Just like the chart?

Dr. LEE. Yes, sir.

Mr. PICKLE. And that is what we would compare.

Dr. LEE. Well, it is in the appendix. There is an appendix to the testimony that describes the method.

Mr. PICKLE. I see. Fine. Thank you.

Now, when we considered reconciliation in the past, we used an inherently reasonable approach. You did not use that measure in this study. You used a different approach, relative value.

Why did you change? I understood you to say a few minutes ago that it was because an inherently reasonable charge was so very complicated. Am I quoting you correctly?

Dr. LEE. The procedures that were established to determine inherent reasonableness has resulted in the fact that the Administration has not made any recommendations under that authority. Under the law that established the Commission, we were directed to comment on any administration proposals that were made under that authority. There have been none, so that we did not make our recommendations within that inherent reasonableness framework because our judgment is that the complexity has led to the Health Care Financing Administration not yet making recommendations using that authority.

Mr. PICKLE. Well, it puzzles me why you used a different measurement with this relative value than the inherently reasonable approach. You tell me that the inherently reasonable approach is very complicated and too hard to administer. I would like to know what do you use, then, in the relative value approach that makes this more simple. All I get from your testimony is you have said you would use relative values. Basically, you use resource costs, reflect market consideration, and input from physicians. That is all I get on how you used the relative value approach.

Dr. LEE. In order to respond to this committee's specific request to the Commission for a technical method that would assist in determining procedures that were overvalued relative to other procedures, we explored different approaches to that. This was in specific response to the request by this subcommittee. This method that

we have presented to you was the best method that we could come up with to provide you with an approach to this problem.

Mr. PICKLE. Well, Doctor, I do not know that I am getting anywhere with you. Am I correct that, in making a recommendation to us regarding which procedures are overpriced and which are not overpriced, you used a different methodology than what we have used previously to establish Medicare payments.

Dr. LEE. Correct.

Mr. PICKLE. I am just wondering why, and what is the advantage of it. I hope I can find it in your testimony. I just want to see what the difference is.

Dr. LEE. Paul, do you want to comment on that?

Mr. GINSBURG. Yes. Mr. Pickle, I think there is a distinction between an administrative process by which procedures are examined to see which ones are overvalued, which is what HCFA is supposed to do, and then the technical methodology to actually identify the procedures.

Now, HCFA for this year has come to the Congress proposing that cataract surgery be reduced because their technical methods indicate that it is overpriced. Our technical methods are different from HCFA's. They are not necessarily in conflict. In fact, on that particular area, cataract surgery, the results were the same: that our method identified it as overvalued as did HCFA's method.

I think the difference is whether suggestions should come right through the Congress for inclusion in the budget reconciliation legislation versus the use of an administrative regulatory process outside of the Congress, which is what inherent reasonableness appears to refer to.

Mr. PICKLE. Well, I do not guess any of us knows what is the proper charge to make on something. It seems to me like we are trying to put a dollar-and-cents tag on every kind of operation and every kind of medical treatment. I do not think there is a science that is that accurate or fair, but I do not know a better system.

It seems to me like we are not giving proper balance at times to either the skill or the training or the type of operation, the risk involved, the resources of the marketplace—any of those things. How you arrive at a system is difficult, no matter what yardstick you use.

Dr. LEE. Absolutely right.

Mr. PICKLE. I would hate to see a price tag put on all these operations, but we are trying to save money. I guess you just have to look at it one way or another, and each of us pass our own judgment. I do not question your findings, but I do worry sometimes about how you got to them. I understand you got it from four States. What four States did you use?

Dr. LEE. The four states that were used in the Medicare study, I believe, were Washington——

Mr. PICKLE. I am talking about the over valued procedures.

Dr. LEE. The Medicare column is based on a previous study of all of the charges for Medicare payments in four States, and those four States were Washington, Connecticut, Alabama, and Wisconsin.

Mr. PICKLE. All right. Are they just representative States?

Dr. LEE. They were regionally representative. How representative they were otherwise, you know, that would be——

Mr. PICKLE. All right. How did Canada come in there? Was Canada included in this study, too?

Dr. LEE. Yes. a relative value scale from Canada is included because they have had many years of experience in negotiating fee schedules in their national health insurance program with physicians. The relative values, in fact, are physician-determined within that system. So we were interested in what it would look like if the physicians determined the relative values, and that is the reason that was selected.

Mr. PICKLE. Why did you want to make a very sharp distinction, as I remember it, in payment to a new physician as compared to an established physician?

Dr. LEE. We did not initiate that procedure, Mr. Pickle. That was an earlier administration proposal. Because of that, we examined it to see what the recommendations of the Commission would be.

Now, there is some feeling that older, more experienced physicians should, in fact, be paid more for their services than younger physicians. But on the other side, you could say, well, they are better trained, they have got the latest knowledge. Our view of that, after we looked at the proposal, was that what had been proposed was not a good approach. There is an existing policy, and we recommended that you continue with that policy rather than further modify it.

Mr. PICKLE. What would be the current policy about that?

Dr. LEE. The current policy basically would be, because of the time that has passed since the initial policy, that new physicians would probably be paid in most communities relatively close to the same as an experienced physician for the same service, for the same code.

Mr. PICKLE. Well, I misunderstood your testimony, then. I thought you were saying that you would pay new physicians less.

Dr. LEE. No. When the policy was first established by the Congress to reduce the payments to new physicians, there has been sufficient time passed so that their charges, as I understand it, and the payments that they receive are relatively now close to more experienced physicians for the same service.

Mr. PICKLE. I will find that in your testimony.

Dr. LEE. And that is consistent with our view about a relative value scale that we should move to a relative value scale where you do not differentiate between a new physician entering practice; and particularly we were concerned if a policy such as had been proposed was implemented, that physicians desiring to move into an underserved area would be discouraged from doing that.

Mr. PICKLE. I am looking to see your appendix, and I see where it is attached to your testimony. Thank you, Dr. Lee.

Chairman STARK. Would it be appropriate, Dr. Lee, if we were to pick a dollar amount and request your Commission to suggest to us which procedures we ought to reduce and by what percentage or by what amount? Would you be prepared to recommend to this committee actual reductions?

Dr. LEE. I think we could do that, but I think the Congressional Budget Office might be able to give you better estimates of what your savings would be if you reduced particular procedures.

Chairman STARK. I am not suggesting what the savings would be. I am suggesting which ones. In other words, we have had one suggestion. It is my understanding that HCFA has testified we ought to reduce cataract surgery. I think that implicit in your testimony is that perhaps we ought to look at cardiac bypass and hip replacement and prostate surgery in addition.

Dr. LEE. Oh, yes. Yes.

Chairman STARK. Now, what I am suggesting is that at some point, obviously, some of us cannot even pronounce these procedures, the committee must decide that we are going to make these cuts. We would look to somebody to give us some expert recommendations as to which procedures and how much. I am asking if you would be prepared to present that to us.

Dr. LEE. I think we would respond to such a request, yes, sir.

Mr. GRADISON. Would the Chairman yield?

Chairman STARK. I would be glad to yield.

Mr. GRADISON. Mr. Chairman, I can understand why you might prefer to initiate that process by setting out a specific savings goal. I personally would be more interested in doing without the saving goal and just asking the Commission for their professional recommendations to us in writing as to which procedures, based on their work so far, are unreasonably priced and how they should be changed. Then we can get it priced out separately.

The reason for this suggestion is that I would think there would be a better chance that a recommendation that came out of that kind of a process might gain broader acceptance than a suggestion which looked like it was forced to meet a specific number which might or might not be the appropriate number in light of what your research indicates.

Dr. LEE. Yes. I think we would prefer that kind of request. Also, with your earlier comments, we would like to continue to explore with this subcommittee and your staff the possibility of a policy that could, in fact, then provide the direction for the Health Care Financing Administration, so that you would not have to annually go through this list of procedures. You know, it is not the most appropriate setting for determining relative values.

Chairman STARK. Thank you very much.

Dr. LEE. Thank you, sir.

Chairman STARK. The next panel will consist of Dr. Nicholas Davies, American College of Physicians; Dr. Robert Graham, representing the American Academy of Family Physicians; Dr. Hunter Stokes, representing the American Academy of Ophthalmology; Dr. Jack Dodick, representing the American Academy of Cataract and Refractive Surgery; Dr. Reginald Cooper, representing the American Academy of Orthopaedic Surgeons; Dr. John Albers, representing the Society of Thoracic Surgeons; and Dr. H. Logan Holtgrewe, representing the American Urological Association.

As the witnesses are finding seats at the witness table, I would suggest to all of you that your prepared testimony will appear in the record without objection in its entirety. We will run the clock for you and ourselves, and that's only in fairness to those of you toward the end, and ask that you summarize in 5 minutes. Explain it to us in any way you care to, and we'll then try to expand on it as we inquire, or other members of the committee inquire.

So I will just ask you to lead off in the order you're listed. Dr. Davies, if you would start, and each member of the panel just identify yourselves and proceed when the other is finished.

Welcome to the committee, gentlemen. Dr. Davies, why don't you proceed in any manner you are comfortable.

STATEMENT OF NICHOLAS E. DAVIES, M.D., MEMBER, BOARD OF REGENTS, AMERICAN COLLEGE OF PHYSICIANS

Dr. DAVIES. Thank you, Mr. Chairman, and members of the subcommittee.

I am Nicholas Davies, an internist in the practice of internal medicine. I serve as chairman of the department of medicine at Piedmont Hospital in Atlanta, and I am also clinical professor of medicine at Emory University. I am here today representing the American College of Physicians and its 65,000 members.

For several years, the college has strongly advocated that short-term budget reductions should be consonant with long-term objectives for reform of the physician payment system. We welcomed the establishment by Congress of the Physician Payment Review Commission as an effort to bring careful deliberation, reasoned analysis, and any hard data that is available to the study of a highly volatile policy area, namely how physicians are paid for their services.

The college's recommendations have continued to emphasize the need to achieve both short-term savings and interim reform of the system through policies, that:

No. 1, reduce payments for those procedures that are overpriced, and there are certainly a good number of these.

No. 2, raise payments for those essential and necessary services that are underpriced. There are not so many of these, but they are terribly important to our Nation's health.

And, third, eliminate payments for those procedures that are outmoded, ineffective or unnecessary.

It is our view that although extensive research efforts are needed to achieve definitive long-term Medicare payment reforms, some steps can be taken promptly to revise the current physician payment system as we await essential results of the ongoing research studies. Such modifications can provide immediate budgetary savings and still be consonant with the goals of overall reform. Accordingly, the college has been pleased with the thoughtful approach reflected in the March 1987 report of the Physician Payment Review Commission.

For the short term, we favor efforts to achieve Medicare savings by reducing payments for those services that are overpriced rather than by across-the-board reduction in all physician payments. Clearly, Medicare payments for some medical and surgical procedures are artificially high, while payments for others are ridiculously low. This disparity has risen in part because the payment methodology based on customary, reasonable and prevailing charges has tended to lock into place the relative pricing patterns that were in existence at the beginning of the Medicare program, paying handsomely for technological and procedural services, and underpaying, or not covering at all, certain non-procedural services

that I lump under the term "cognitive," things such as physical examinations, history taking, patient counseling, and patient education.

So we were pleased with the Commission's endorsement of the inherent reasonableness approach, and we strongly support their most recent efforts to arrive at an interim methodology for identifying appropriate areas for reduction. We urge the Congress to utilize such an approach as a basis for short-term budget reductions for the coming fiscal year.

At the same time, we feel strongly that Medicare and other purchasers of health care services must provide equitable payment for properly rendered services. We strongly support the concept of inherent reasonableness, and we believe that limiting payments for those procedures that have been overpriced as a far preferable means of budget reduction than is imposition of an arbitrary across-the-board reduction.

We are also strongly supportive of efforts to develop a relative value scale for Medicare.

In looking at adjustments for underpriced services, we have expressed opposition to contemplated across-the-board reductions in the Medicare economic index that would apply equally to under paid services, as well as to those services that are overpaid.

We support the Commission's recommendations that adjustments could be made in applying the updates to prevailing charges based on the MEI, in order to encourage provision of primary care services, particularly in underserved areas. This kind of adjustment would tend to moderate the gross inequities of an across-the-board cutback and would be preferable to a blanket elimination of MEI adjustment.

Certainly, primary care services, including office visits, home visits, nursing home visits should be protected from the reduction in the MEI. We would go even further. We would recommend that a portion of any savings achieved through reduction of the MEI be used to supplement payments for such underpriced services.

We would also urge that consideration be given to using a portion of the savings to pay for preventive health services, patient counseling and patient education.

In closing, let me note that the American College of Physicians has for many years led the way in developing sound data to eliminate unneeded and inappropriate medical services. Our Clinical Efficacy Assessment Project has determined the medical necessity and clinical efficacy of many medical tests and treatments setting a higher standard for technology assessment.

Most recently, we have worked with the Blue Cross and Blue Shield Association to develop guidelines for common diagnostic tests. So we are heavily involved in helping physicians provide excellent care at reasonable cost. At the same time, we must argue forcibly for redress for those services provided by the physician to the elderly that are very much needed and that are inappropriately reimbursed or not paid for at all.

Thank you for the opportunity to appear before you to present our views.

[The statement of Dr. Davies follows:]

STATEMENT
of the
AMERICAN COLLEGE OF PHYSICIANS
before the
HOUSE WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

June 15, 1987

The American College of Physicians (ACP) is pleased to have this opportunity to appear before you today to outline our priorities concerning Fiscal Year 1988 budget reconciliation issues related to physician payment under the Medicare program and to comment on issues raised by the Physician Payment Review Commission. I am Nicholas E. Davies, M.D., F.A.C.P., an internist in the private practice of internal medicine; I serve as Chairman of the Department of Medicine of Piedmont Hospital, Atlanta, Georgia and am also Clinical Professor of Medicine, Emory University School of Medicine. I am here today representing the American College of Physicians as a member of its Board of Regents.

The College represents over 65,000 doctors of internal medicine, subspecialists, and physicians-in-training. Our membership includes private practitioners delivering primary health care; medical specialists in such fields as gastroenterology, endocrinology, oncology, and cardiology; medical educators; and researchers. Since its inception in 1915, the College has sought to uphold high standards in medical education, medic' practice, and medical research. As payment policies have increasingly affected each of these areas, the College has become extensively involved in issues raised by physician payment policy.

Overview

For several years the American College of Physicians has strongly advocated that short-term budget reductions should be consonant with long-term objectives for reform of the physician payment system. We welcomed Congressional establishment of the Physician Payment Review Commission as an effort to bring careful deliberation and reasoned analysis to a highly volatile policy area--namely, how physicians are paid for the services they deliver.

Our recommendations have continued to emphasize the need to achieve both short-term savings and interim reform of the system through policies that:

1) reduce payments for those procedures that are overpriced;

2) raise payments for those essential and necessary services that are underpriced; and

3) eliminate payments for those procedures that are outmoded, ineffective or unnecessary.

It is our view that although extensive research efforts are needed to achieve definitive long-term Medicare payment reform, some steps can be taken promptly to revise the current physician payment system, as we await essential results of ongoing research studies. Such modifications can provide needed budgetary savings and still be consonant with the goals of overall reform. Accordingly, the College has been pleased with the thoughtful approach reflected in the March 1987 report of the Physician Payment Review Commission. In that report, the Commission set forth an agenda for long-term physician payment reform that we hope will lead to needed improvements in the current payment system and will result in correction of payment inequities that are inherent in the current payment system.

As noted, for the short-term, we favor efforts to achieve Medicare savings by reducing payments for those services that are overpriced rather than by across-the-board reductions in all physician payments. We were pleased with the Commission's endorsement of the inherent reasonableness approach in their March report to the Congress, and we strongly support their more recent efforts to arrive at an interim methodology for identifying appropriate areas for reduction. We urge the Congress to utilize such an approach as the basis for short-term budget reductions for the coming fiscal year.

At the same time, we feel strongly that Medicare, as well as other purchasers of health care services, must provide adequate and equitable payment for appropriately rendered services, and will urge that you build upon the recommendations of the Commission with respect to payment for primary care services and services in underserved areas. It is our view that this is essential to continuing to use short-term changes to foster long-term reform.

Selected Reductions in Overpriced Services

An option for short-term budget savings considered by the Physician Peer Review Commission and before you today is that of selective reductions in medical and surgical procedures for which current Medicare payments are excessive. Clearly, Medicare payments for some medical and surgical procedures are artificially high, while payments for others are ridiculously low. These disparities have arisen in part because the payment methodology based on customary, reasonable and prevailing charges has tended to lock into place the relative pricing patterns that were in existence at the inception of the Medicare program, paying highly for technological and procedural services and underpaying (or not covering) non-procedural services such as physical examinations, patient history taking, diagnostic evaluations, and patient counseling and education.

Further disparities have occurred because of the inability of the payment system to adjust prices in accordance with changes in availability and costs of services. Thus, when a new, highly sophisticated technological procedure is developed, charges may initially be extremely high, reflecting developmental costs and availability from only a relatively few physicians and surgeons possessing requisite skills and training. As relevant medical and scientific knowledge is disseminated, medical skills advance, the procedure becomes more commonplace, and efficiencies in utilization are achieved; price reductions should occur. However, the current payment system, which reflects historical prices, and the medical marketplace, which is relatively insensitive to such competitive forces, tend to perpetuate payments for procedural services at excessively high levels.

One method to correct for these market distortions and to achieve short-term budget savings is to adjust Medicare payments on the basis of inherent reasonableness. We believe that limiting payments for those procedures that have become overpriced is a more preferable means of obtaining budget savings than imposition of arbitrary across-the-board reductions. Furthermore, we believe it is an appropriate goal of Medicare to establish a process for reducing excessive payments for specific Medicare services. Consequently, the College has been supportive of recent regulatory efforts to better define "inherent reasonableness" and to adjust Medicare payments accordingly. The College has also been supportive of the Physician Peer Review Commission in its efforts to develop a relative value system for Medicare and in its efforts to identify medical and surgical procedures that are overpriced. The Commission has now developed a methodology for comparing payments under Medicare with those under systems that are based on objective determinations of relative values. Some of those findings have been presented to you today. While these findings are preliminary and only apply to a limited number of procedures, we believe that this is an important interim step in developing a fairer and more objectively determined payment system. We would reiterate our support for using this approach to identify budget savings for the coming fiscal year.

Adjustments for Underpriced Services

In recent testimony before the Physician Payment Review Commission, we expressed our opposition to contemplated across-the-board reductions in the Medicare Economic Index (MEI) that would apply equally to underpaid services as well as to those that are now overpaid.

We supported the Commission's recommendation in its report of March 1, 1987 that adjustments could be made in applying the updates of prevailing charges based on the Medicare Economic Index (MEI) to encourage provision of primary care services, particularly in underserved areas. We feel that this kind of adjustment would tend to moderate the gross inequities of an across-the-board cutback and would be preferable to a blanket elimination of the MEI adjustment.

We strongly support the Commission's more recent recommendation that primary care services--such as, office visits, home visits, and nursing home visits--be protected from any reduction made in the anticipated MEI. However, we would go even further than this and recommend that a portion of any savings achieved through reduction of the MEI be used to further adjust payments for such underpriced services. We would also urge that some consideration be given to using a portion of savings to pay for preventive health services such as geriatric assessments, and patient counseling and education.

Conclusion

Mr. Chairman, the College believes that Medicare as well as other purchasers of health care services should provide adequate and equitable payment for appropriately rendered services.The College believes that it is extremely important, especially in these times of budgetary deficits and economic constraints, to assure that appropriate health care services of good quality are provided safely and effectively and to focus cost-reduction efforts on services that are overpriced, unnecessary, ineffective or inappropriate.

The College's overall approach to payment system reform has been guided by several principles that we believe are needed for a clinically-effective reimbursement system:

- First, the goal of the payment system should be to pay appropriately for effective services.
- Second, it should not perpetuate incentives for excessive, inappropriate, or ineffective care.
- Third, it should be based, to the extent possible, on objective, quantifiable data, rather than on historical or normative charges, "opinions," or anecdotes.
- Fourth, it should be flexible enough to foster effective innovation and to be modified in the face of valid changes in medical practice.
- Fifth, it should take the patient into account.

For these reasons, the College believes that long-term reform of the service-based reimbursement system are needed. We are hopeful that work by the Physician Payment Review Commission on developing relative value scales will lead to a more equitable payment system. We are also encouraged that modifications based on resource use, that take into account the effectiveness of the service and the outcome of the patient, are being considered.

For the short-term, if choices have to be made to achieve budgetary target savings, we prefer that the savings be achieved by limiting payments that are determined to be inherently unreasonable. We believe that this is fully consistent with short-term budget needs and the need for long-term Medicare payment reform. Secondly, we believe that a stage has been reached where some relief is needed for certain clearly underpriced services and services in certain settings. Relief is needed now as an interim step, as we await long-term reform of the payment system. Lastly, we oppose across-the-board reductions

in Medicare adjustments to allowable prevailing charges, except to the extent that savings from such reductions are used to correct some of the historical inequities that have led to underpayments for primary care services.

In closing, let me note that the American College of Physicians has for many years led the way in developing sound data to eliminate unneeded and inappropriate medical services. The activities of our Clinical Efficacy Assessment Project in determining the medical necessity and clinical efficacy of various medical tests and treatments are unprecedented among medical organizations and have helped to set the standard for technology assessment. Through our medical education activities we seek to continually advance the profession's understanding of what is and is not known about the usefulness of various clinical approaches.

Our recent, widely publicized work with the Blue Cross and Blue Shield Association in developing guidelines for the use of common diagnostic tests was one more effort in this long history. The Blue Cross and Blue Shield Association has indicated that it believes implementation of the guidelines will result in significant patient care savings and improve quality of care. But frankly, at the same time that the College works towards enhancing quality and cost-effectiveness of care by applying rigorous scientific standards that potentially may result in payment denials for some services, we must also argue forcefully for some redress for those services that are very much needed and which therefore should be appropriately reimbursed.

Thank you for this opportunity to appear before you to present our views. I would be pleased to respond to any questions that you may have.

Chairman STARK. Thank you.
Dr. Graham.

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. GRAHAM. Mr. Chairman, I am Dr. Robert Graham, the executive vice president of the American Academy of Family Physicians, an association of some 59,000 members, reflecting the interests and concerns of family physicians throughout the United States.

Given the discussion which the committee has already heard this afternoon about a number of the issues before it, I would just like to highlight several areas of particular concern that the academy has regarding proposals for physician payment reform in the current fiscal year.

First, as Dr. Davies has already addressed, we are very concerned about a proposal for an across-the-board freeze of the MEI. We believe that the present provision of the MEI index may already be discriminatory against primary care physicians, and we would urge the Commission's consideration of the proposal that certain services, particularly those provided in the office, the home, or skilled nursing facilities be exempted from a freeze on the MEI, and indeed that consideration be given to allowing the full adjustment necessary under the present MEI index for these services.

We would point out that this is not specifically an issue which is of benefit to primary care physicians, but could apply to any physician providing services in those sites.

Secondly, we would oppose the suggestion for an across-the-board cut or cap on prevailings for certain index procedures. We believe that although savings might be accomplished by doing this, that the method itself is inequitable. And we would urge the committee's consideration that if any attempt is to be made to achieve fee adjustments in certain index procedures, that this be done by taking the totality of prevailings, either nationally or region by region, doing some type of average or weighted average, and then determining which outliers within those prevailings should be capped or reduced.

We believe that in taking this latter approach the committee would have the assurance that it was not arbitrarily penalizing by an across-the-board reduction, a physician or physicians who have priced their services or their procedures responsibly while taking cognizance of the fact that there are some who are indeed the outliers which the committee has indicated its concern.

Third, we do oppose the administration's proposal to revise the reimbursement basis for new physicians to 80 percent of the prevailing.

New physicians or new physicians in practice already face considerable difficulties under the MAAC program, and we believe that this proposal would further exacerbate those difficulties.

Already the MAAC program has based fee charges on a time period for which some physicians, newly in practice, or other physicians who were not providing a specific service at that time, have no base rate. That is why we have joined with a number of other medical organizations in urging that the MAAC program itself, al-

though fraught with more difficulties than it is possible to cite at the present time, at a minimum be revised to provide for a new basing period of July 1, 1985, through June 30, 1986, and that this new basing period be made retroactive for physician charges to January 1, 1987.

We would urge the committee's consideration of this action in lieu of the administration's proposal that I referred to above for new physicians.

Mr. Chairman, a number of the other issues that have already been discussed with the committee are of substantial interest to us this afternoon, but rather than go into those in detail, having highlighted these three points, I will simply again thank the committee for the opportunity to provide these remarks, and await any questions that you may have.

[The statement of Dr. Graham follows:]

STATEMENT OF ROBERT GRAHAM, M.D., AMERICAN ACADEMY OF FAMILY PHYSICIANS

Mr. Chairman, my name is Robert Graham, M.D. and I serve as Executive Vice President of the American Academy of Family Physicians. The Academy is the national medical specialty organization which represents more than 59,000 family physicians, family practice residents and medical students.

On behalf of the Academy, I am pleased to have the opportunity to again appear before this subcommittee to share the views of our members on the subject of Medicare physician payment policies. In the following statement I would like to discuss with you the various strategies for short term budgetary savings in the Medicare program which have been considered by the Physician Payment Review Commission from the standpoint of family physicians and their patients.

At the outset, I would emphasize that continuing to target Medicare payments for physician services may have a substantial adverse affect on access to critically needed curative and preventive services. The Academy believes that two goals should govern reform of physician reimbursement; access to quality health care by the Medicare population and equity in payment for physicians. Efforts by Congress to address the budget deficit should be crafted in a manner which is not contrary to these goals. Dollars should not be saved at the expense of the health of the Medicare beneficiary.

Further reductions or limitations on Medicare Part B payment will have a detrimental effect on family physicians and their patients. The types of services provided by family physicians—ambulatory based, preventive oriented—are cost effective and already are reimbursed at very low levels. These are not the services which account for large Medicare outlays. These are not the services which are driving up the cost of the program. These are the types of services which are aimed at keeping people healthy, active and mobile and potentially reducing acute care costs. Yet access to these services will be reduced by further cuts in Medicare payment.

The Academy therefore believes that Congress should apply any reductions in Medicare Part B payment selectively, to take into account the disparities in payment that currently result for primary care as opposed to procedurally oriented services. In this way, short term changes in Medicare will move in the direction of longer term reform.

One means of accomplishing this is to target the Medicare Economic Index through a freeze or reduction in the amount by which prevailing charges are updated for all but primary care services. An across the board freeze or reduction in the MEI would disproportionately hurt family physicians and their patients. The services already reimbursed at inappropriately low levels would be subject to the same payment reductions as higher priced services. A selective adjustment in the MEI to allow the full MEI for primary care services would be a more equitable approach. A definition of primary care services which we would suggest, and which has been used previously in the context of a similar proposal, would include office, home and skilled nursing facility visits. A provision of this type would not favor one specialty over another, yet would permit an increase in the reimbursement for those services which tend to be reimbursed at lower levels relative to technically and procedurally-oriented services.

The second strategy which we would like to address is the "inherent reasonableness" option that would reduce prevailing charges for a list of procedures regarded

as outliers. One method of accomplishing this would apply a uniform percentage reduction in the adjusted prevailing charges for the procedures targeted; the suggested percentage reduction is 10 percent.

One concern we have with this approach is that all of the prevailing charges for each of the procedures identified as outliers would be reduced. Because prevailing charges vary tremendously for a given service, the Academy believes that rather than the application of an across the board reduction, PPRC should develop a methodology to identify and reduce the prevailing charges for a procedure that are high relative to other prevailing charges for the same procedure. Such an approach would target the high priced provider rather than all providers who perform a given service, whether or not the charges for the service are inappropriately high.

Another interpretation of the inherent reasonableness concept has been suggested to reduce the magnitude of the variations in fees for Medicare similar services. The proposal would, in the case of each physician service reimbursed in a state, limit payment to no more than a certain percentage above the average prevailing charge in a state. In a state with multiple localities, this new limit may reduce payment in those localities with the highest prevailing charges.

A weighted national average of state average charges also could be calculated and payment limited to no more than some percentage above this national average, reducing payment in areas with prevailing charges significantly above the national average charge levels.

This approach may have merit as it does address the above noted concern about the potential inequity of an across the board reduction in the prevailing charge levels for a procedure identified as an outlier. It also raises a potential additional budget savings. In many localities Medicare carriers determine different prevailing fees for different types of specialists providing the same services, which results in separate prevailing charges for family physicians. If this proposal were to be implemented so that an average prevailing charge is established for a given service based on the prevailing charges for all physicians providing the service, we believe this might be a reasonable approach. However, we would not support the establishment of a specialty by specialty average prevailing charge as this would result in placing a cap on the prevailing charge for family physicians which would be different—and generally lower—than the cap on the prevailing charge for other specialists providing the same service.

Of course, as I expressed to this subcommittee in March, the American Academy of Family Physicians has been adamantly opposed to the establishment of dual prevailing charges under the Medicare program. In June 1986 the U.S. Supreme Court ruled that two lower courts did have jurisdiction in determining that the Medicare regulation allowing different prevailing fees for different types of specialists providing the same service, is in violation of the Medicare statute. We believe that as a result the Health Care Financing Administration has a responsibilty to revoke this regulation and to provide for a single prevailing fee for the same service, regardless of the specialty of the physician providing the service. Establishment of a single prevailing fee for a given service is technically feasible in the near term and could be consistent with the above recommendation.

The third option that we would like to address would change the basis of reimbursement for new physicians. This option was proposed in the President's budget and essentially would limit the physician's reimbursement to 80 percent of the adjusted prevailing rather than the 50th percentile of customary charges, as is currently the case.

We note that this proposal is projected by the CBO to result in savings of $114 million in 1988 and we therefore, assume that limiting new physicians to 80 percent of the adjusted prevailing rather than the 50th percentile of customary charges will further reduce Medicare reimbursement for services provided by so called "new physicians." We believe that arbitrarily targeting this group for further reductions is inappropriate.

The single aspect of the recently implemented MAAC requirements which has generated the greatest outcry of dissatisfaction among our members is the requirement which limits new physicians to the 50th percentile of customary charges. In many instances, this provision has resulted in very substantial reductions in the amount which such physicians receive for caring for Medicare patients and has resulted in MAACs which are substantially below the charges which these physicians have ever made for providing the particular service.

This strategy poses particular problems for family practice. Reimbursement for family physicians under Medicare currently is disproportionately low for physicians who have been practicing for many years. The customary charges which currently are used in the calculation of reimbursement for new family physicians therefore

are low. Low prevailing charges, which reflect the impact of years of specialty and geographic differentials limit what family physicians are reimbursed for their services. We therefore believe that it would be highly inappropriate to save Medicare dollars by imposing restrictions which will provide disincentives for physicians to train and practice family medicine. Faced with debts for their medical education, the high costs of establishing a medical practice, including payment of high malpractice insurance premiums, students already are turning away from family practice. Should the Medicare reimbursement for new physicians be reduced to achieve a short term Medicare cost savings, the direct result may well be to further discourage physicians from training in family practice and other primary care specialties or to provide a substantial disincentive for such physicians to provide care to Medicare beneficiaries.

To address this and other inequities with the MAAC program, the Academy has joined with several other medical organizations to ask Congress to adopt an amendment which would do the following:

1. Base each physician's MAACs on his or her own current established customary charge profile (i.e. actual charges submitted from July 1, 1985 to June 30, 1986).

2. Provide physicians with access to MAAC information in a timely fashion for making future participation decisions.

3. Make the proposed changes in the MAAC methodology retroactive to January 1, 1987.

These changes to the MAAC program would eliminate the unfair rollbacks in their established fees experienced by physicians who entered practice from July 1, 1984—June 30, 1986, and by established physicians who did not provide a particular service during the April-June 1984 current base quarter. In addition, the amendment would simplify administration of the program by Medicare carriers by requiring that they maintain one, instead of two, profiles for each physician. We would encourage the Subcommittee to incorporate these changes into the budget reconciliation package.

In summary, the American Academy of Family Physicians does not believe that Congress should target Medicare payment for physician services in its efforts to achieve budget savings in FY 1988. Primary care services, which are cost effective, already are reimbursed disproportionately low relative to procedurally oriented services. Further budget reductions which do not address this disparity in Medicare payment policy will further discourage beneficiary access to these services. As the committee develops its strategies for reducing Medicare spending the American Academy of Family Physicians would suggest that consideration be given to an adjustment in the MEI which takes into account primary care services, or an adjustment in Medicare reimbursement for those services and to those providers for which payment is inappropriately high or inappropriately low, through the inherent reasonableness authority. Further, the Academy strongly urges that the subcommittee reject efforts to save Medicare dollars at the expense of new physicians and, instead, adjust the MAAC limits for these physicians to reflect their actual charges.

We have appreciated the opportunity to share our views with you today and look forward to working with you in developing your Medicare payment recommendations. I would be pleased to answer your questions at this time.

Chairman STARK. Thank you very much.

Dr. Stokes.

STATEMENT OF HUNTER STOKES, M.D., SECRETARY FOR GOVERNMENTAL RELATIONS, AMERICAN ACADEMY OF OPHTHALMOLOGY

Dr. STOKES. Thank you, Mr. Chairman, members of the subcommittee. My name is Dr. Hunter Stokes. I am an ophthalmologist in private practice in Florence, SC, and serve as secretary for governmental relations of the American Academy of Ophthalmology. I am speaking on behalf of the academy, whose membership represents over 15,000, or about 93 percent of the ophthalmologists in the United States.

My testimony will emphasize four points: that cataract surgery, No. 1, is a delicate, highly successful procedure that should not be penalized because it is successful. No. 2, that cataract surgery has

experienced more reimbursement reductions over the last 4 years than any other procedure and, therefore, should not be included in this year's budget cuts. No. 3, that the impact of the 1986 enacted 12 percent prevailing cut, and special cap on actual charges has not been studied and hence no further cuts should be made until Congress can be assured that patient care, quality, access and patterns of practice have not been negatively affected by the existing reductions. And, finally, that HHS may be sending signals to providers that Medicare is more concerned with quantity and not quality of care, especially in terms of the unbundling of cataract postoperative care.

We wish to stress that we appreciate the opportunity to be here today to continue our interest in working with you and your staff in achieving a mutual goal. We strongly believe that the worthy goal of designing a more rational, equitable physician payment system will not be met through the selective and divisive reductions in certain procedures, especially the continual barrage aimed at cataract reimbursement.

First, cataract surgery is a very successful procedure that is often misunderstood. It is extremely complex, performed under a power microscope on an area of the body smaller than my thumb with sutures that are not even visible to the unaided eye. Many technological advances in medicine, such as the CAT scan and laser surgery have actually reduced physician involvement in the procedure. Not so with cataract surgery. With increased technology, the new method of cataract extraction with intraocular lens implantation actually makes the job technically more difficult.

It is largely patient demand which has resulted in the high volume of cataract surgery. Patients demand the surgery because they want to lead more active lives, to be more self-sufficient. The development of cataracts is often an inevitable result of the aging process. Older Americans do not wish to sacrifice their independence or quality of life to the encroaching blindness of cataracts, given the 98 percent success rate of the operation.

Despite the progress in the operation, its quality, and success, it continues to come under continued scrutiny from Congress, largely because of the volume of cases, over a million for this year. As a result, cataract surgery has shouldered more than its fair share of part B cuts over the last 4 years. These reductions include:

A 12-percent reduction in the surgeon's fee.

A cap on actual charges. Cataract is the only Medicare procedure subject to a specific rollback in the physician's actual charges.

The use of an assistant surgeon has essentially been eliminated.

The payment to an anesthesiologist for monitoring cataract surgery has been cut more than 30 percent.

PRO's have moved cataract surgery to the outpatient setting.

Hospital outpatient reimbursement has been reformed.

And this fall, when the PRO's implement their second surgical opinion program, it is likely that no cataract surgery will be permitted by Medicare until it has expressed prior approval.

Due to these changes, cataract surgery as a package is now significantly less expensive to the Medicare program and to the beneficiary. We believe it is unfair to contemplate any further reduc-

tions in 1988. It is unfair because we were the test case in last year's inherent reasonableness experiment.

We have further concerns with the method of choosing the overpriced procedures. And our written testimony provides details of our concerns.

We recognize your goal of reducing Medicare outlays. We think savings could be achieved by congressional direction to HHS to maintain the integrity of the global surgical fee. Currently, HHS allows postoperative care for cataract surgery alone to be unbundled and provided separately by nonphysicians. Not only is this fragmentation costly to the Medicare program, it is unethical,

Natural referral patterns between generalists and surgical specialists, or between surgeons and allied help providers should be maintained. In the case of cataract surgery, the unbundling which presently is permitted, not only endorses patient abandonment, but creates an environment where certain surgeons are indirectly rewarded for abandoning patients. This practice institutionalizes fee splitting.

Medicare allows no other procedure to split fees this way. We urge you to put a stop to the costly and unethical unbundling of postoperative care.

In closing, we support the position of the AMA that physicians have been subjected to years of fee freezes and other burdensome program changes. We also support the efforts of the American College of Surgeons in exploring long-term system-wide adjustments.

We recommend that substantive policy changes not be proposed without further study. And, finally, we believe that cataract surgery has already shouldered its fair share of Federal budget cuts and should not be a part of any new reduction package.

Thank you very much for this opportunity to voice our comments. And we look forward to working with you and your staff. Thank you.

[The statement of Dr. Stokes follows:]

STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

My name is Hunter Stokes, MD. I am an ophthalmologist in private practice in Florence, South Carolina, and Secretary for Governmental Relations of the American Academy of Ophthalmology. I am speaking on behalf of the Academy, whose membership represents more than 15,000 or 93 percent of the ophthalmologists in the U.S.

Our testimony will emphasize these points: (1) that cataract surgery is a delicate, highly successful procedure that should not be penalized for its success; (2) that cataract surgery has experienced more reimbursement reductions over the last four years than any other procedure, and therefore, should not be included in this year's budget cuts; (3) that the impact of the 1986 enacted 12 percent prevailing cut and special cap on actual charges for cataract surgery has not been studied, and hence, no further cuts should be made until Congress can be assured that patient care, quality, access, and patterns of practice have not been negatively affected by the existing reductions; and (4) that HHS may be sending signals to providers that Medicare is more concerned with quantity not quality of care, especially in terms of the unbundling of cataract postoperative care.

We wish to stress that we appreciate the opportunity to be here today, and to continue our sincere interest in working with you and your staff to achieve our mutual long-term goal. We strongly believe that the worthy goal of designing a more rational, equitable physician payment system, however, will not be met through the selective and divisive reductions in certain surgical procedures, especially the continual barrage aimed at cataract surgery reimbursement. Cataract surgery is a very successful procedure that is often misunderstood. It is extremely complex surgery, per-

formed under a powerful microscope on an area of the body smaller than my thumb, with sutures that are invisible to the unaided eye.

Unlike the CAT scan, where technology replaces exploratory surgery, or lasers, where the technology permits surgery without a blade, the technology associated with cataract surgery places great demands on the surgeon's skills. The surgeon must still cut into the delicate tissues of the eye with a knife—precisely—or lose the eye. Then, using tiny forceps, the surgeon places an intraocular lens—measured by ultrasound to fit the unique shape of the patient's eye—through a tiny slit, into just the right location, in the same small, fragile pocket where the clouded natural lens was carefully removed. While expensive new technology is an integral part of modern cataract surgery, it has made the "job" harder, not easier for the surgeon.

The advances in the technical skills of the surgeon, quality of the knife blades, the microscope, the sutures, and the intraocular lens implants have greatly improved the success of cataract surgery, reduced the complication rates, and greatly enhanced the patient's visual outcome. These results, coupled with the use of local anesthesia which permits one-day surgery, have greatly increased the public's demand for this operation.

It is largely patient demand which has resulted in the high volume of cataract surgery. Patients demand this surgery because they want to lead more active lives, to be more self-sufficient. The development of cataracts is all too often an inevitable result of the human aging process. Older Americans do not wish to sacrifice their independence or quality of life to the encroaching blindness of cataracts, especially given the 98% success rate of modern cataract surgery.

Despite the progress in cataract surgery, in its quality and success, it has come under continual scrutiny from Congress, largely because of the volume of cases, over 1 million surgeries performed yearly. As a result, cataract surgery has shouldered more than its fair share of Part B cuts over the last four years. These reductions include:

A 12 percent in the surgeons fee.

A cap on actual charges, only 25 percent over the prevailing fee, or the MAAC calculation, whichever is lower. This is the only Medicare procedure subject to a specific roll-back of the physicians actual charges. The special cap on cataract fees provides a permanent mechanism to hold down the surgeon's actual charges, reduce the beneficiary's out-of-pocket expense, and strictly limit the amount Medicare will pay for the foreseeable future.

The use of an assistant surgeon has been nearly eliminated in most areas.

The payment to the anesthesiologist for monitored anesthesia services only during cataract surgery has been cut significantly.

Peer Review Organizations have moved cataract surgery to the outpatient setting. Today, it is virtually impossible to admit a cataract patient even for an overnight stay, no matter how frail the patient or what social factors are present.

Hospital outpatient reimbursement and ambulatory surgery center payments have been reformed for program savings.

This fall, when the Peer Review Organizations implement their second surgical opinion program, it is likely that no cataract surgery will be permitted under Medicare unless it has expressed pre-approval.

Due to these changes, cataract surgery, as a package, is now significantly less expensive to the Medicare program, and to the beneficiary.

Further, these policies have altered cataract surgery in ways that might not become apparent for some time. We respectfully urge you to refrain from any further reductions in cataract surgery reimbursement until proper studies can show us what impact these changes have had on quality of care, patient access and physician practice patterns.

We believe it is unfair to contemplate any further reductions in cataract surgery fees in 1988. It is unfair because we were the "test case" in last year's inherent reasonableness experiment. It is unfair because of the inequities of a further straight percentage across-the-board cut. It is unreasonable because it perpetuates the many other inequities and inconsistencies of the usual-customary-prevailing fee system inherent in the national Medicare system.

We have further concerns with the method of choosing the "overpriced" procedures. The Mitchell-Stason study, which has been cited as a reference, selected the highest volume Medicare procedures in four states, in 1984. This was before any of the above-noted changes in cataract surgery were enacted. We take issue with the data and methodology used in their study:

(1) Higher volume tends to reflect higher success; by singling out these procedures, you may penalize success, and attack the procedures which the patients demand.

(2) The data available (1984) is out-of-date for cataract surgery, and inadequate; only high volume procedures were chosen in order to perform statistical manipulations, and the statistics will be subject to larger margins of error. Even Dr. William Hsiao, who constructed the 1985 relative value scale upon which Mitchell and Stason base their study, has indicted that the 1985 RVS needed significant refinement; that individual values could be subject to as much as a 25 percent error rate.

(3) Modern medical practice, technique and supplies change rapidly, enough so that 1984 data may not accurately reflect 1988's Medicare care.

We are all aware of the difficulties in collecting and analyzing national Medicare data. Because of this, the actual impact of the recommended across-the-board percentage cuts in the selected procedures is difficult to assess, especially in terms of the greater likelihood that rural areas and physicians who have kept their fees at moderate levels would be hit hardest.

As we respectively remind you, that for cataract surgery, the Administration's proposal would result in a total reduction of 25 percent over two years. Such a larger cut clearly raises larger risks and uncertainties for the Medicare program. Just last year, Congress declared that such a significant reduction was not acceptable, and therefore enacted the 10 percent cut.

While we vehemently object to any further reductions in cataract surgery reimbursement, it is possible that program savings could be achieved by Congressional direction to HHS to maintain the integrity of the global surgical fee. Currently, HHS allows post-operative care for catarat surgery alone to be unbundled, and provided separately by non-physicians. Not only is this fragmentation costly to the Medicare program, it is unethical. Natural referral patterns between generalists and surgical specialists or surgeons and allied health professionals should be maintained. HCFA should be directed to pursue reasonable definitions of services which may include bundling. In the case of cataract surgery the unbundling which presently is allowed to exist not only endorses patient abandonment but creates an environment where certain surgeons are indirectly rewarded for abandoning patients. This has institutionalized fee splitting.

In closing, we support the American Medical Association's position that physicians have been subjected to years of fee freezes, MAACs and other burdensome program changes. This constant barrage should stop, until a rational, equitable reform can be crafted. We also support the efforts of the American College of Surgeons in exploring long term, systemwide adjustments aimed at equitable solutions to some of the Medicare payment problems.

We recommend that substantive policy changes not be proposed without further study. And finally, we believe that cataract surgery has already shouldered its fair share of federal budget cuts and should NOT be part of any new reduction package.

Thank you for this opportunity to voice our comments. We look forward to working with you and your staff.

Mr. COYNE [presiding]. Thank you.

Dr. Dodick.

STATEMENT OF JACK DODICK, M.D., DIRECTOR, GOVERNMENT AFFAIRS, AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY

Dr. DODICK. Thank you, Mr. Chairman. My name is Dr. Jack Dodick, and I am from New York City.

I consider it a personal honor to be invited on behalf of the Cataract Society to address this subcommittee.

I will be brief, pertinent, and try to make four recommendations to this body for cost cutting.

The Cataract Society that I represent is a scientific and educational association of over 4,500 ophthalmologists who are primarily interested in anterior segment eye surgery, including cataract extraction with the implantation of an intraocular lens.

Congress has, it seems to us, essentially only two options for general approaches to short-term cuts in Medicare physician reimbursement.

First, it's some form of broad across-the-board reductions that would affect all or most physicians who treat Medicare patients.

Second is more focal on reimbursement for a few medical procedures based on what we now know as inherent reasonableness.

I will merely summarize our society's positions and the reasons for them, but I note that they are discussed more extensively in the written statement that we have submitted.

We, the Cataract Society, oppose the second approach inherent reasonableness reductions, and respectfully urge Congress to adopt whatever options most broadly and, therefore, most fairly spread out necessary budget cuts amongst Medicare reimbursed physicians. The inherent reasonableness option would be redundant for us who perform cataract surgery because Congress has already specifically reduced prevailing changes in cataract surgery fees in the fiscal year 1987 and again in 1988.

Congress has also established a system for use by health care financing administrators in evaluating Medicare physician reimbursements based upon inherent reasonableness. That system is essentially an administrative, not a legislative one.

Finally, the relative value scale work previously identified by HCFA and the Physician Payment Review Commission for use in an inherent reasonableness approach to adjusting Medicare reimbursement for cataract surgery is extremely preliminary and does not provide accurate indicators of the relative value of physician services. That study relies heavily on time on task measurements. It arbitrarily weights time and complexity and, in our opinion, very poorly measures complexity.

Reliance upon that RVS work by Congress must result in payment reductions that would be unsubstantiated and, in our opinion, arbitrary and unfair.

Congress has reduced cataract surgery fees in the fiscal year 1987 by 10 percent and prevailing charges for cataract surgery in fiscal year 1988 by an additional 2 percent. No other surgical procedures were singled out by Congress for these reductions.

If Congress were to now address several procedures, including cataract surgery for fiscal year 1988, reductions on the basis of inherent reasonableness, cataract surgery reimbursement would be subject to singularly redundant and unjustifiable additional reductions.

Well, let's now get to the meat. We, the Cataract Society, do not argue that there must be no further changes in cataract surgery reimbursement by Medicare. First, it is too early to evaluate the overt inherent reasonableness changes for they have not even been fully implemented. But other kinds of changes in cataract surgery reimbursement by Medicare might increase its efficiency and fairness, assuming there are no additional inherent reasonableness changes.

First, Medicare reimbursement for the intraocular lens purchased by ophthalmologists is often too high. Medicare carriers in many States continue to reimburse for this device at $300 to $400 levels. Many implant models can be purchased at considerably

lower amounts. Therefore Congress should consider declaring that Medicare reimbursement for an implant purchased by an ophthalmologist shall not be higher than the acquisition cost plus a nominal handling charge subject to a maximum amount as determined by the carrier.

As an example, let me point out that if a million lenses are implanted in Medicare beneficiaries, even a cost cutting of $50 per lens would result in a cost saving of $50 million. If that were expanded to $100 per lens, the cost savings then would be expanded to $100 million.

Second, I would respectfully recommend that much has been written about bundling physician services for Medicare reimbursement. In fact, the cataract surgery physician's fee is already bundled. Medicare reimburses a global fee for most preoperative and postoperative services of the ophthalmologist. However, there still do remain some procedures frequently performed in connection with cataract surgery and not universally included by Medicare carriers in a global fee.

Study would be necessary to identify procedures which might be appropriate for further bundling. This may be possible.

Third, there is geographic disparity in cataract surgery reimbursement. Medicare prevailing charges for cataract and implant surgery in 1985 varied among geographic regions by 114 percent.

Savings might result from averaging because higher reimbursement amounts for cataract surgery seem to occur with higher populations of the elderly, and therefore, higher incidence of cataract surgery.

Fourth, and lastly, savings can be effected in Medicare reimbursement for physician services in performing cataract surgeries through enforcement of existing Medicare fraud and abuse laws.

Deliberate fraud and abuse in Medicare reimbursement for cataract surgery can occur, in my opinion is uncommon, but by its extensive educational efforts in this area, our society has become in effect the prime reinforcement agency, as acknowledged informally by HCFA.

In conclusion, Mr. Chairman, and members of this committee, the Cataract Society recommends, finally, that its recommendations be considered for short-term modifications in Medicare physician reimbursement for cataract surgery.

I thank you for this time to present this testimony.

[The statement of Dr. Dodick follows:]

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

STATEMENT
OF THE
AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY
BY
JACK DODICK, M.D.*
JUNE 15, 1987

The American Society of Cataract and Refractive Surgery submits these views to the Subcommittee on Health in connection with its efforts to effect budget reconciliation for Fiscal Year 1988 through reductions in Medicare payments for physicians' services. The Cataract Society understands and respects the need for our federal government to act responsibly with respect to reduction of overall budget deficits. It recognizes, too, that even such crucial programs as those providing medical reimbursement for the aged must be closely scrutinized for possible contributions to budget reductions.

The Cataract Society wishes to offer its views and recommendations with respect to (1) the general approach of the Congress on reducing Medicare payments for physicians' services and (2) some specific areas worthy of consideration to achieve reductions in Medicare reimbursement for cataract surgery.

First, the general approach.

Among the options available to the Congress in reducing Medicare payments for physicians' services, two general approaches stand out as possibilities.

First, some broad, across-the-board reductions can be made with respect to all payments under the Medicare Part B program for physicians' services. This could be done by a simple percentage reduction in prevailing charges nationwide for all Medicare Part B physician reimbursement. The Physician Payment Review Commission has considered an alternative whereby there would be a reduction in the updating of prevailing charges by the Medicare Economic Index.[1/] A variation of this broad, across-the-board-approach might be to identify large categories of physicians by experience, nature of practice, or other features (office-based vs. surgical, "cognitive" vs. "hands-on", experienced vs. newer physician, etc.). The PPRC also has

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* Jack Dodick, M.D. is a Member of the Scientific Advisory Board of the American Society of Cataract and Refractive Surgery and Director of Government Affairs for ASCRS. He has practiced ophthalmology, including cataract surgery, for over twenty years. His M.D. is from the University of Toronto; his residency training was at Philadelphia General Hospital. He is currently Ophthalmologist-in-Chief and Surgeon Director at Manhattan Eye, Ear & Throat Hospital, New York, and Associate Clinical Professor of Ophthalmology at Columbia University.

1/ Letter of May 14, 1987 to several medical organizations including ASCRS from Paul B. Ginsburg, Ph.D., Executive Director of the PPRC.

considered one form of this -- reduction in reimbursement for Medicare-defined "new physicians."[2]

The second option available to Congress as a general approach would be to focus on Medicare physician reimbursement for a few frequently-performed services or procedures for which current reimbursement is thought to be excessive. Prevailing charges would be reduced nationwide for those services or procedures exclusively. This is the so-called "inherent reasonableness" approach. It was first proposed as a way to adjust Medicare rates nationwide by the Health Care Financing Administration in 1986.[3] It was endorsed for use by HCFA in budget reconciliation legislation last year, although according to carefully described criteria and using specific comparisons.[4] Again, the PPRC has considered reduction in prevailing charges for some Medicare-reimbursed procedures based upon "inherent reasonableness."[5]

In reaching its Medicare budget reconciliation reductions in physician payments for FY 1988, the Cataract Society urges Congress to the avoid utilization of the second option, the "inherent reasonableness" approach, because it would be redundant and excessive if applied to cataract surgery, and, overall, the results would be unsubstantiated, arbitrary and unfair. The Cataract Society urges Congress instead to utilize whatever form of the first option that it finds would most broadly and uniformly spread any necessary budget reductions throughout the Medicare physician reimbursement program.

The Cataract Society has additional specific recommendations for other possible approaches to meeting Congressional budget targets.

ASCRS

The Cataract Society is a national scientific and educational professional society of some 4,500 ophthalmologists (physician eye specialists) who perform cataract surgery. The organization was formed in 1974 as the American Intra-Ocular Implant Society.

Its primary endeavors are the presentation of scientific symposia and the publication of a peer-reviewed journal on cataract surgery, intraocular lens implantation, and other aspects of anterior segment eye surgery. The Cataract Society believes that its membership includes the vast majority of all United States ophthalmologists who regularly perform cataract/IOL surgery.

Cataract is the condition of the eye, usually occurring because of the normal human aging process, in which the eye's natural crystalline lens becomes clouded and impairs vision. In cataract surgery, the ophthalmologist removes the opacified portion of the lens and, usually, replaces it with a permanently-implanted clear plastic intraocular lens.

2/ Id.

3/ Proposed regulations, 51 Fed. Reg. 8726 (Mar. 18, 1986); final regulation, 51 Fed. Reg. 28716 (Aug. 11, 1986).

4/ Omnibus Budget Reconciliation Act, P.L. 99-509 at § 9305 (1986).

5/ Id. p. 1.

In 1987, it is estimated that between 1.25 and 1.5 million patients will have cataract surgery performed. The average age of a cataract patient is estimated to be 70 years; thus, the overwhelming majority are eligible for reimbursement of their expenses under the Medicare program. The annual Medicare outlays for physicians' services for cataract/IOL surgery are estimated to be about $1 billion. Among all of the specialities and subspecialities of medicine, cataract surgery is likely the most immediately and most universally affected by budget cuts in Medicare payments for physicians' services.

THE CATARACT SOCIETY OPPOSES THE "INHERENT REASONABLENESS" OPTION

The Cataract Society strongly urges Congress that it not attempt to meet budget targets for Medicare physician payments in FY 1988 through an "inherent reasonableness" approach.

That approach would be redundant for ophthalmologists who perform cataract surgery, because Congress has already specifically reduced prevailing charges for cataract surgery in FY 1987 and FY 1988. In addition, Congress has itself established appropriate criteria for evaluation of Medicare physician reimburrement based upon "inherent reasonableness". Those criteria should be addressed by an appropriate administrative agency based upon the requisite notice and comment rulemaking procedure, not in the necessarily rushed Congressional budget process. Finally, reference points previously identified by the HCFA or the PPRC in these "inherent reasonableness" approaches have been extremely unreliable indicators of the relative value of physicians' services; reliance upon them by Congress would result in payment reductions that would be unsubstantiated, arbitrary and unfair.

1. Congress Has Already Reduced Cataract Surgery Reimbursement

Last year the Health Care Financing Administration proposed and finalized a controversial regulation by which it assumed authority to modify Medicare reimbursement nationwide for particular procedures when the reimbursement was not "inherently reasonable". Many doubted that HCFA had authority to do this on a nationwide basis.[6] The first procedure that HCFA proposed to address under "inherent reasonableness" authority was cataract surgery. The agency conducted a study of the 30 hospitals in the United States at which cataract surgery was most frequently performed; it determined that cataract surgery with the implantation of an intraocular lens took about the same amount of time at those hospitals as cataract surgery without an IOL. HCFA proposed that prevailing charges for cataract/IOL surgery be reduced in steps nationwide to 10% above prevailing charges for cataract surgery alone.[7]

Among many challengers opposing the HCFA proposal, the Cataract Society filed extensive comments that exposed serious flaws in the agency's methodology. A supplementary report to the Cataract Society by the highly regarded health care reimbursement firm of Lewin and Associates discussed the gaps and weaknesses in the surgical time study as well as in several published reports that had been cited by the

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6/ See comments submitted in response to the proposed regulation identified in n. 3.

7/ See 51 Fed. Reg. 29321 (Aug. 15, 1986).

agency. Ultimately, however, Congress itself preempted finalization of the HCFA proposal on cataract surgery.

In its Omnibus Budget Reconciliation Act,[8] Congress ended the controversy over HCFA authority to make nationwide modifications in Medicare physician payments using the "inherent reasonableness" approach. It specifically granted that authority and made it subject to a list of criteria.[9] In OBRA Congress also addressed cataract surgery physician reimbursement.[10] Congress reduced Medicare prevailing charges for cataract surgery in FY 1987 by 10%. It reduced prevailing charges for cataract surgery in FY 1988 by an additional 7%. No other medical or surgical procedures were singled out by Congress for reductions in Medicare payments to physicians.[11]

If Congress were to subject several procedures, including cataract surgery, to physician payment reductions on the basis of "inherent reasonableness" for FY 1988, cataract surgery reimbursement would be subject to singularly redundant and excessive additional reductions.

Congress should exclude and exempt cataract surgery if it proceeds with any other Medicare physician payment reductions based upon "inherent reasonableness".

2. The HCFA and PPRC "Inherent Reasonableness" Approaches Have Been Seriously Flawed

In OBRA, Congress laid out in detail a strategy for Medicare physician payment policy.[12] An important element of that strategy, to achieve short-term reform, is the specification of a process for HCFA as an administrative agency to implement "inherent reasonableness" review of physician reimbursement. Congress has appropriately encouraged HCFA to reduce physician fees for overpriced services. But it has also mandated a system for identifying overpriced procedures and for determining the extent to which those procedures are overpriced. Congress listed six circumstances in which nationwide Medicare rate adjustments would be appropriate and four methods of comparison as the bases for the adjustments to be used by HCFA in "inherent reasonableness" determinations.[13]

8/ Id. ss. 4.

9/ Id.

10/ See id. at § 9314(a).

11/ In addition to cuts in Medicare reimbursement for ophthalmologists who perform cataract surgery, Congress also ratified HCFA's reduction in payments for anesthesia services in connection with cataract surgery. Id. at §9314(b).

12/ See generally Statement of Cong. Bill Gradison before this Committee, March 3, 1987.

13/ See id. n.5. In summary, the six circumstances in which an adjustment in Medicare payment for a procedure may be appropriate are where: previously charges are significantly different from those in comparable localities; Medicare is the sole or primary source of payment; the marketplace is not truly competitive; there have been increases not explained by inflation or technology; the charges do not reflect technology; there is increased facility with the technology or reduced costs; or the

(Footnote Continued)

Congress has also already effectively made its own "inherent reasonableness" determination with respect to cataract surgery. It is therefore unnecessary and inappropriate to again address cataract surgery physician reimbursement at least until the changes effected by Congress can be evaluated.

Any "inherent reasonableness" determinations by Congress would presumably rely upon preliminary relative value scale work identified and discussed by both HCFA and PPRC in its previous considerations of "inherent reasonableness" approaches to Medicare physician reimbursement reductions. Two works in particular have been repeatedly cited as appropriate bases for the "inherent reasonableness" approach.

Work by Professor Hsiao on a "resource-based relative value scale"[14] has been cited by both HCFA and PPRC and has been reported on directly to this Subcommittee. Likewise the Mitchell-Stason report[15] on Medicare relative values has been used as a basis for comparison of physician fees by HCFA and PPRC.

The Cataract Society addressed the most recent Hsiao work and the Mitchell-Stason Study very extensively on its own, and through submission of a supplemental report by the firm of Lewin and Associates, in response to the HCFA proposal last year on cataract surgery physician reimbursement reductions. An abstract of the Cataract Society's pertinent comments, and the entire Lewin and Associates submission, appear as Attachment 1 to this Statement.

Greatly summarized, a number of serious flaws in the Hsiao and Mitchell-Stason studies were noted. With respect to the Hsiao work:

- It is not meant to be used to judge compensation. The second Hsiao work makes no attempt to evaluate how physicians should be paid for services; it only addresses the value of medical procedures in relation to one another; it does not support the conclusion that any one or a few procedures are overpriced, as Dr. Hsiao has himself acknowledged in the work.

- It makes arbitrary assessments of complexity. As a primarily time-based study, the Hsiao work has been severely criticized in a report under contract to HCFA as unreliable for the proper measurement of compensation for medical services; physicians' time is not combined in fixed proportion with other resources; measuring

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(Footnote continued)
charges are substantially different than those of other payers. The four methods of comparison are: between charges and resource costs for related procedures; between charges and resource costs for a procedure over a period of time; between charges for a procedure in different geographic areas; or between charges paid by Medicare and by other payers. There must be substantial economic justification for a nationwide Medicare payment; there must be proposed and final actions by HCFA.

[14] Hsiao, Braun, et al., "Final Report: Resource Based Relative Values of Selected Medical and Surgical Procedures in Massachusetts" (Dec. 1985).

[15] Center for Health Economics Research, "What Should Medicare Pay for Surgical Procedures?" (June, 1986).

relative physicians' time alone is a poor indication of costs; adjustments to time to reflect complexity of procedures must of necessity be arbitrary ones.

- It is sensitive to weighting. Dr. Hsiao gives equal weight to "time-on-task" and "complexity", or risk, skill and judgment; even minor changes to the weighting of these factors produces radically different results under Hsiao's methodology, as demonstrated by the Lewin and Associates analysis.

With respect to the Mitchell-Stason Study:

- It is based on Hsiao's work. Having adopted the Hsiao methodology, the Mitchell-Stason Study necessarily transfers, or even amplifies, the concerns expressed above.

- It depends upon arbitrary index procedures. The Study adopts particular procedures as precisely priced and measures others against those index procedures; the authors acknowledge this problem and suggest further work on it.

5) ASCRS Recommendations for a Relative Value Scale

Preliminary work on primarily time-based relative value scales, such as the work of Hsiao and Mitchell-Stason, is not suitable for Congress to use to base short-range determinations on Medicare physician reimbursement for some procedures in an "inherent reasonableness" approach. Among other infirmities, that preliminary RVS work relies excessively on time measurements, arbitrarily weights time and complexity, and very poorly measures complexity. Any "inherent reasonableness" determinations based upon that work will inevitably be unsubstantiated, arbitrary and unfair.

Congress has offered to HCFA its own "inherent reasonableness" criteria for use in these short-range determinations which Congress should allow to be followed.[16]

Having questioned the relative value scale work to date as a proper basis for "inherent reasonableness" determinations, however, the Cataract Society would be remiss if it did not offer recommendations to Congress for the future direction of work on relative value scales.

Congress has ordered the Department of Health and Human Services to develop a relative value scale for physicians' services and to report to Congress on it by July 1, 1989.[17] Two members of the Cataract Society's Scientific Advisory Board are among the four members of a panel of ophthalmologists responsible for providing expert assistance in the Harvard/AMA relative value scale project pursuant to the HHS obligation imposed by Congress.

The development of a relative value scale for physicians' services reimbursed by Medicare, mandated by Congress to be performed by HHS, is admittedly a long-range effort rather than a short-range one. It is therefore not directly germane to the present mission of Congress on short-range methodologies to meet FY 1988 budget targets.

16/ See id. n. 9.

17/ P.L. 99-272, §9305(b) (1986).

Nevertheless these recommendations on RVS development are offered to Congress by the Cataract Society.

First, preliminary work to date on a "resource-based relative value scale" has focused too much on the time it takes to perform physicians' services. Time is measurable; it is not surprising that scientific researchers favor time measurement when attempting to compare the value of physicians' services. However, physicians do not perceive their own work, are not perceived by patients, are not now reimbursed, and should not in the future be reimbursed, as only "hourly fee" professionals. Time-on-task measurement of physicians' services is a trap for the unwary. Cataract surgery, for example, has been characterized as "a routine procedure that takes 45 minutes to perform".[18/] In fact, of course, the 45-minute measurement is inadequate. Cataract surgery time varies considerably depending upon patient condition and surgeon methodology.[19/] Moreover, Medicare reimbursement for cataract surgery is on a "global fee" basis -- it covers extensive preoperative, operative and postoperative services that often involve a considerable commitment of a physician's time and attention to patient care. Finally, the cognitive function of the surgeon in today's highly complex cataract procedure is enormous. In short, the Cataract Society recommends that Congress consider how some now frequently-publicized studies, such as that of Dr. Hsiao, can inaccurately reflect actual physician time reimbursed by Medicare and, even more important, that time-on-task should not be given undue weight in evaluating the relative value of physicians' services.

Second, more scientific analyses must be conducted as to the complexity of medical services. The Hsiao and Mitchell-Stason work makes assumptions regarding complexity that the researchers admit are arbitrary ones.[20/] Both rely on interviews with a small number of physicians as a gauge of the complexity of cataract surgery, for example. It is likely that no physician can assess the complexity of a medical procedure, whether within that physician's specialty or not, without significant bias. Other methods beyond consultations with physicians must be found to help determine the relative complexity of medical procedures for purposes of developing a relative value scale.

Third, whether as a function of the study of medical procedure complexity or otherwise, the Cataract Society recommends consideration of several factors that it regards as "orphans" in the relative value scale work to date:

- Patient risk. Some methodology should be developed to assess the relative perceptions of patients in subjecting themselves to medical procedures performed by physicians. With respect to cataract surgery, patients are nearly always the elderly who have gradually lost full functional vision and greatly fear blindness. They subject

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18/ Statement of Chairman Pete Stark before this Subcommittee, March 3, 1987, pp. 2-3.

19/ The HCFA time study of cataract surgery last year was severly criticized because no methodology was published, there were apparently no standards used for time measurement and HCFA studied only the 30 highest volume, and presumably most efficient, cataract surgical facilities. See Attachment 1.

20/ See Attachment 1.

themselves to an elective procedure that has as one of its risks, although thankfully a remote one, the risk of blindness. Many patients regard the risk of blindness as greater than the risk of death. Patient risk is an important factor in determining the "value" of a medical procedure.

- Patient benefit. Another crucial measurement of the relative "value" of physicians' services in connection with various medical procedures is the perception of patients regarding the benefit to be achieved. The main reason that cataract surgery has proliferated, in addition to a vastly improved medical procedure and to the fact of an increasing old age population, is the enormous efficacy of the procedure. Patients often regard themselves as functionally "reborn" following successful cataract surgery. Their quality of life is almost always improved dramatically. The Cataract Society has recently arranged to fund a study at Johns Hopkins University School of Hygiene and Public Health regarding the patient benefits of cataract surgery. This factor cannot be disregarded in an attempt to relate the value of one medical procedure to another.

- Technical Sophistication. Preliminary relative value scale work has failed to adequately address elements of technical sophistication of medical procedures reviewed, but has instead relied only upon comments of a non-representative population of inevitably biased physicians. The technical sophistication of cataract surgery today, for example, is truly awesome. A listing of operation techniques of an uncomplicated cataract surgery procedure is included as Attachment 2 to this Statement. Cataract surgery demands that each of many intricate microsurgical steps must be performed with absolute precision to achieve a successful functional vision result for the patient. Clearly some methodology beyond seeking comments from physicians should be developed to measure the complexity of medical procedures for an RVS.

- Research. The extent to which the performance of a medical procedure includes a "by-product" of research should also be measured. In cataract surgery, for example, virtually all of the major revolutionary technical changes in the last 50 years have been developed in the course of clinical practice, rather than through traditional academic research. This is true with respect to intraocular lens implantation itself, the phakoemulsification procedure for extracapsular cataract extraction, development of modern IOL designs, the YAG laser surgery technique for posterior capsulotomy, etc. A recent survey commissioned by the Cataract Society and conducted by Bonner & Associates demonstrates that fully a third of clinical practitioners in cataract surgery are conducting or planning research.[21] What value we places upon cataract surgery should reflect the research component.

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[21] "Report of Survey of ASCRS Members," Bonner & Associates, Washington, DC, Apr., 1987, p. 2. (available from the Cataract Society).

Education. An important "resource" to be considered in comparing the value of medical procedures is the extent of continuing education that is required. Cataract surgery has evolved so consistently and extensively that cataract surgeons must commonly attend several scientific symposia each year to stay abreast of clinical research. A recent study revealed that cataract surgeons spend at least five hours per week doing professional reading or viewing professional video tapes.[22/] The requirements of education to successfully perform one medical procedure versus another is an important element of "relative value."

The Cataract Society is aware that a relative value scale can never measure one physician service against another accurately and completely. However, a useful measurement system can be approached. The preliminary work in this area is just that, preliminary. It should not be relied upon by Congress as adequate to make short-range "inherent reasonableness" determinations. In the longer range it should be modified to increase its accuracy and therefore its utility.

OTHER SHORT-RANGE OPTIONS FOR MEETING BUDGET TARGETS

It would be myopic for the Cataract Society to argue that there must be no changes in cataract surgery reimbursement by Medicare. Criticism of that reimbursement prior to the OBRA changes by Congress last year, although refuted by the Cataract Society, came from many quarters. It is too early to evaluate the OBRA changes; they have not yet even been fully implemented. But no doubt further changes can be made in Medicare cataract surgery reimbursement to increase efficiency and fairness. The Cataract Society believes strongly that the option of focusing on a few procedures, for adjustment arbitrarily using an "inherent reasonableness" approach, is ill-advised. It is redundant because cataract surgery is already subject to Congressional reductions. And it is improper because any "inherent reasonableness" approach should be conducted by an administrative agency according to due process and avoiding inadequate, irrelevant or unscientific bases. Nevertheless, the Cataract Society does have suggestions for assisting in meeting Congressional budget targets on a short-range basis with respect to Medicare reimbursement for physicians' services in performing cataract surgery, assuming there are no further so-called "inherent reasonableness" changes implemented by Congress.

First, Medicare reimbursement for intraocular lenses themselves when purchased by ophthalmologists is often inappropriately high. HCFA recognized this problem and has repeatedly suggested that Medicare carriers conduct their own individual "inherent reasonableness" reviews.[23/] So far many carriers have apparently either not conducted the reviews or have not reduced IOL reimbursement as a result. Medicare carriers in many states, such as Florida and Texas for example, continue to reimburse for

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22/ Id. p. 3.

23/ Medicare Carriers Manual, Transmittal No. 1129, Oct., 1985, §5241; Transmittal No. B-86-1, Jan., 1986; Transmittal No. 1180, Mar., 1987, § 5240.1.

ophthalmologist-purchased IOLs at the rate of $300-$400.[24/] And yet many IOL models can be purchased from manufacturers at considerably lower amounts. The subject is explained fully in a communication recently sent to all Cataract Society members which is included with this Statement as Attachment 3. Congress should consider declaring that Medicare reimbursement for an intraocular lens purchased by the ophthalmologist should be in an amount no higher than the acquisition cost plus a nominal handling charge, with the IOL reimbursement subject to a maximum amount determined by the Medicare carrier under "inherent reasonableness" methodology.

Second, much has been written about the possibility of "bundling" physicians' services that are now individually reimbursed into larger packages.[25/] In fact, the cataract surgery physician's fee has been bundled since the inception of the Medicare program. Medicare now reimburses a "global fee" for most preoperative, operative and postoperative services of the ophthalmologist in connection with cataract surgery. However, there do remain some procedures performed in connection with cataract surgery and not universally included or bundled by Medicare carriers into the cataract surgery global fee which might be appropriate for further bundling. Study would be necessary to identify procedures that are frequently performed in connection with cataract/IOL surgery but that are not now bundled by carriers.

Third is the subject of geographic disparity in cataract surgery reimbursement. Medicare prevailing charges for typical cataract/IOL surgery in FY 1985 varied by geographic region from $1,166 to $2,500, a difference of 114%.[26/] While practice costs and practice patterns may justify a reasonable disparity among geographic locales in physician global fee reimbursement for cataract surgery, the present enormous disparity is simply not warranted. If it can be effected administratively without undue bureaucracy, the Cataract Society favors a change whereby carriers would be required to "average out" cataract surgery reimbursement amounts by state or region, subject to some allowances for areas that have unusually high or low basic costs of practice. It might seem that savings to the Medicare program would not result by simply averaging reinbursement amounts by state or region. In fact, however, savings could result from averaging because higher reimbursement amounts for cataract surgery seem to occur in areas with higher populations of elderly and therefore higher incidence of cataract surgery.[27/] Further study, of course, would be necessary to determine this.

Fourth, savings can be effected in Medicare reimbursement for physicians' services in performing cataract surgery through improvements in enforcement of

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24/ See "Cataract IOL Surgery Reimbursement under Medicare; Present Methodologies and Payments with Impending Changes," Health Coverage Strategies, Inc., Edina, MN, Oct., 1986.

25/ See for example, Statement of Philip R. Lee, MD, Chairman of the PPRC, before this Subcommittee, March 3, 1987, p.7.

26/ See Table 4 of Lewin and Associates' comments in Attachment 1.

27/ See id. Reimbursement rates in "Sunbelt" states of California, Nevada, New Mexico, Arizona, and Texas were all above the national average.

existing Medicare "fraud and abuse" laws. The Cataract Society believes that deliberate fraud and abuse in Medicare reimbursement for cataract surgery is uncommon, but it does occur. The Cataract Society has issued dozens of communications to members on avoiding prohibited payments such as inducements for IOL purchases, referral fees to other professionals, etc. [28] By its educational efforts in this area, the Cataract Society has become, in effect, the primary "enforcement" agency, as acknowledged informally by HCFA. But instances of fraud and abuse, however abhorrent, no doubt continue to exist. [29] There has been inadequate official enforcement by the federal government of Medicare fraud and abuse laws. With respect to fraud and abuse through kickbacks, bonuses or rebates such as in connection with the purchase of intraocular lenses, there has been virtually no enforcement by Medicare. Neither HCFA nor the Attorney General will assist in educational efforts such as those of the Cataract Society even by advising as to the scope and applicability of the fraud and abuse laws to specific factual situations in cataract surgery. [30] Congress should consider a program of increased enforcement of these laws.

CONCLUSION

In conclusion, the American Society of Cataract and Refractive Surgery respectfully submits to this Subcommittee that, in meeting Fiscal Year 1988 budget targets through changes in Medicare reimbursement for physicians' services, any "inherent reasonableness" option be avoided. Application of an "inherent reasonableness" approach to cataract surgery would be redundant, because Congress has already reduced cataract surgery reimbursement by Medicare in FY 1987 and FY 1988. There has not yet been sufficient time to evaluate the results of those reductions. Moreover, in general, an "inherent reasonableness" approach is best performed by an administrative agency such as HCFA utilizing due process and avoiding reliance upon inadequate, irrelevant or flawed data. For Congress to utilize an "inherent reasonableness" approach would necessarily result in Medicare reimbursement changes for physicians that are unsubstantiated, arbitrary or unfair. The Cataract Society recommends finally that its recommendations be considered with respect to long-term development of a relative value scale and with respect to short-term modifications in Medicare physician reimbursement for cataract surgery.

28/ See for example, Attachment 3.

29/ See report on "Cataract Surgery: Fraud, Waste and Abuse," Select Committee on Aging, Subcommittee on Health and Long-Term Care, U.S. House of Representations, July 19, 1985.

30/ Cong. Claude Pepper requested interpretations by letter to the Attorney General of December 18, 1985; the response was not helpful. The Cataract Society has itself unsuccessfully sought interpretations from HCFA, from the HCFA Office of Inspector General and from the Department of Justice.

Attachment 1

Comments on "Hsiao II" and the "Mitchell-Stason" Studies

Originally submitted by ASCRS in response to the HCFA proposal on cataract surgery reimbursement reductions under Medicare "inherent reasonableness" authority published at 51 Fed. Reg. 29,321 (Aug. 15, 1986)

Comments of the Cataract Society (Extracted)

Hsiao II

One study, prepared by Dr. William C. Hsiao, is a time-based relative value scale study.[1] The Hsiao study attempts to determine the relative value of different medical procedures based in large part on the operating room time necessary to perform them.[2] The Hsiao study has been cited by HCFA to demonstrate that a particular surgical procedure, cataract surgery, is overpriced when compared to other surgical procedures such as appendectomy or cholecystectomy.[3]

The Hsiao study, however, is of questionable reliability in determining whether medical procedures are overcompensated. For one thing, the study itself makes no effort to judge how much a physician should be paid for services. Instead, Hsiao attempted only to determine the relative value of several medical procedures in relation to one another. As Hsiao explained:

> It is important to note that the relative values, which are the output of this study, describe only a set of relationships among a set of services. In order for these relationships to be translated into a set of fees some dollar value per relative value unit must be used. The determination of that dollar value per relative value unit, which is essential to establishing fees that are reasonable with respect to costs, is a critical step. Determining a reasonable dollar value per relative value unit was, however, outside the scope of the present study.[4]

The Hsiao study thus suggests only how medical procedures should be priced in relation to each other. It cannot provide support for the proposition that any one medical procedure is overcompensated. That kind of conclusion is beyond the scope of the Hsiao study.[5]

1/ W. Hsiao, P. Braun, P. Goldman & C. Spencer, "Final Report: Resource Based Relative Values of Selected Medical and Surgical Procedures in Massachusetts" (Dec. 1985) (cited as "Hsiao II").

2/ See, e.g., Hsiao I, at 23-24.

3 See 51 Fed. Reg. at 29,322.

4 Hsiao II, Executive Summary, at 1 (Emphasis added).

5/ Thus, the Hsiao study can determine only that the compensation relationship between two procedures, such as pacemaker insertion and hysterectomy, is inappropriate. But Dr. Hsiao has expressly disclaimed any intention to

(Footnote Continued)

Moreover, the Hsiao study's methodology casts doubt on its reliability as a measure of proper compensation for medical services. Hsiao relies on a time-based relative value scale.

> However, such scales have serious theoretical and implementation problems. The biggest theoretical problem is that physicians' time is not combined in fixed proportions with all of the other resources that go into producing physicians' services. As such, relative physicians' time would be a poor indicator of procedures' relative costs. In principle, time estimates could be adjusted to correct for variations in procedure complexity, the contributions of other inputs, and physicians' investments in their own training. In practice, such adjustments require making several arbitrary assumptions as well as substantial data on practice-related factors other than physicians' time.6/

Indeed, one recent analysis performed under contract for HCFA severely criticizes the Hsiao relative value study for the arbitrary and unsupported assumptions it makes in adjusting procedure time to account for relative complexity, opportunity cost, and overhead.7/

According to this HCFA-sponsored study, the model used by Hsiao,

> is based on two types of assumptions. One set consists of assumptions made because of the lack of data. . . . The other set of assumptions are not amenable to empirical testing and call into question the validity of the model. Another group of researchers or practitioners might have made substantially different judgments regarding these assumptions and, therefore, come up with a quite different result.8/

(Footnote Continued)
determine whether the problem should be corrected by increasing the compensation for hysterectomy or decreasing the compensation of pacemaker insertion. Id.

6/ J. Hadley, D. Juba, K. Swartz, J. Wagner, & R. Berenson, "Alternative Methods of Developing a Relative Value Scale of Physician's Services: Year 1 Report," 96-97 (Feb. 1983).

7/ J. Hadley, D. Juba, R. Berenson, & M. Sulvetta, "Final Report on Alternative Methods of Developing a Relative Value Scale of Physician's Services," The Urban Institute (Apr. 1985)(Prepared under contract of HCFA-500-81-0053).

8/ Id. at 105.

Mitchell-Stason

Another study is one completed in June, 1986, by the Center for Health Economics Research.[9] HCFA has also cited this study to demonstrate that one procedure, cataract surgery, is overpriced as compared to other procedures, such as lung lobectomy, hernia repair, and cholecystectomy.[10]

However, the Mitchell-Stason Study is based entirely on the relative value scales developed by Dr. Hsiao.[11] The shortcomings of the Hsiao studies are equally applicable to the Mitchell-Stason Study. Moreover, the Mitchell-Stason Study reaches its results only by arbitrarily concluding that the prices of particular surgical procedures, such as lung lobectomy, are precisely accurate. There is no evidentiary support for the Study's assumption that it is a particular surgery, rather than the base surgical procedures, which is economically mispriced. Significantly, the authors of the Mitchell-Stason Study themselves recognize shortcomings in their analysis:

> [b]efore implementing such a reimbursement change, however, policymakers should consider two factors. First . . . these analyses should be considered preliminary. More work is needed with an RBRVS based on a larger national sample, and the selection of an appropriate index procedure also needs to be carefully evaluated. Second, so long as physicians may continue to refuse assignment, these potential physician payment reductions will be passed on to beneficiaries in the form of higher out-of-pocket liability.[12]

Moreover, the methodology of the Mitchell-Stason Study in identifying a value for one procedure, cataract surgery, is unscientific and unreliable. The authors formulated the value of cataract surgery, for example, only "[a]fter talking with two local ophthalmologists . . . ."[13] Without identifying these ophthalmologists or their qualifications, and based simply upon their "expert judgment," the authors assigned a value to the one-stage lens procedure.[14] Any conclusions based upon these results are without objective credibility. The Mitchell-Stason Study is at best unscientific and illogical.

9/ Center for Health Economics Research, "What Should Medicare Pay for Surgical Procedures," June, 1986 (cited as the "Mitchell-Stason Study").

10/ Id. at 6-7.

11/ Id.

12/ Id. at 1-5 - 1-7 (Emphasis added).

13/ Id. at 6-2.

14/ Id.

EXCERPTS FROM

LEWIN AND ASSOCIATES REPORT - SEPTEMBER 15, 1986

(Submitted by the American Society of Cataract and Refractive Surgery in response to a proposal by the Health Care Financing Administration that Medicare physician reimbursement for cataract surgery be reduced. 51 F.R. 29321, August 15, 1986).

. . .

In brief, our conclusions . . . can be summarized as follows:

3. The calculations used in the Hsiao and other studies make some fundamental assumptions that have a very significant impact on the results, notably regarding the relative important of "time on task" and "complexity." . . .

4. The implicit assumptions HCFA makes in accepting the Hsiao study method is that in comparing surgical procedures, input factor costs are the appropriate basis for comparison, and that in considering input factor costs, equal weight should be given to time on task and "complexity," or risk, skill, and judgment.

5. . . . Proper application of the Hsiao and the Health Economics Research Study are inconclusive on the specific question of "grossly excessive" prevailing fee screens for CE/IOL. . . .

. . . Two of the studies relied upon by HCFA1 are relative value studies conducted by the Harvard School of Public Health whose principal author is William Hsiao. Neither of these studies includes data on the specific procedure in question, i.e., CE/IOL, but are limited to lens extraction alone, for the years 1978 and 1984, and rely primarily on Massachusetts data. Notably, all assessments of the relative complexity of different surgical procedures were from Massachusetts physicians. In the case of the later and larger study, only 12 Massachusetts ophthalmologists were included.

The third study, conducted by Mitchell and her colleagues at Health Economics Research (the "HER study") relies on the Hsiao study values for determining relative input costs of different procedures, but includes Medicare data from four states. . . .

. . .

Hsiao and his colleagues constructed a set of relative values for medical encounters and surgical procedures by multiplying the quantitative values of four factors, each of which was assigned equal weight. These factors are: "time on task;" complexity (including professional skill, dexterity, and judgment, and risk to the patient); overhead costs; and opportunity costs. The outcome of this calculation is extremely sensitive to the relative weights of these four factors. This is especially critical for lens extraction since Hsiao's showed it to have one of the highest complexity factors, relative to time on task among the procedures studied. This can be seen in Figure 1 (attached), from the first Hsiao study. It can be

seen that lens surgery was an extreme outlier compared to other procedures.

Our own view is that the "equal weight" approach is subject to considerable challenge, even if one believes that input prices are an appropriate way to evaluate charges for surgery. First, the "equal weight" approach appears to ignore the judgments virtually all other payers, and the market in general, appear to have made by their willingness to respectively approve and accept charge levels in rankings that appear to give more weight to complexity, than to time on task. For example, Jack Hadly studied the relationship between relative value scales based solely on charges and relative value scales based solely on time. He found that for surgical procedures the charge (or market) based approach produced estimates more than 600% those of the time based scales, while the difference for office visits was less than 20%. Possible explanations for these findings include either that the more "serious" the situation, the more consumers value factors other than time (i.e., charges reflect the market); or, alternatively, the "market" is distorted because third party payers (most available for surgical procedures) insulate consumers from price. The latter is the view of Hsiao and his colleagues who believe if there were a true competitive market, consumers would pay on a basis that assigned equal weight to time and complexity.

It is absolutely essential that it be understood that the studies cited by HCFA in no way prove or even empirically test whether the market for cataract surgery has been distorted, resulting in "grossly excessive" charges. What has been shown is that the Medicare price per point on the Hsiao relative value scale is substantially greater than the price per point for some other procedures, notably those less technologically intensive.

The data which HCFA relies on indicate that it is only by using Hsiao's "Resource-Based Relative Value Scale" (the RBRVS) that the Medicare price for lens extraction appears "grossly excessive." This is not to say that it might not be possible to provide such data, simply that HCFA has not done so. We are not at present aware of studies which test Hsiao's hypotheses regarding lens surgery and other "high tech" procedures.

The one conclusion which can be drawn from the Hsiao studies and the subsequent HER study which uses the same method, is that charges for certain procedures (including lens extractions) to Medicare and private insurers are higher relative to charges for other procedures) than predicted by the RBRVS method. Is the RBRVS method or the Medicare price for these procedures inappropriate?

For example, Table 1, which we computed from data in the second Hsiao study, shows the percentage amount by which Medicare "over" and "under" pays for lens extraction, using various comparison. Using the RBRVS method, Medicare payments for lens extractions are overpriced, compared to the operations HCFA cites (hysterectomy, appendectomy, cholecystectomy); however, also using the RBRVS method, the lens procedure is underpriced compared to laproscopy (11%) and largngoscopy (10%).

More interesting are the measures of the "appropriateness" of the Medicare price for lens extractions, compared to other procedures, when two relative value scales based on other insurance charge markets (the California

Relative Value Scale and Massachusetts Blue Cross) are used. In those cases, lens extraction appears either appropriately priced,or somewhat underpriced (by Medicare) relative to other procedures.

The extreme sensitivity of conclusions regarding the "appropriateness" of the price of different procedures to the assumptions built into the Hsiao method is illustrated by findings from the HER study. This is the only empirical study cited by HCFA which contains any data at all on the procedure being regulated, namely, the cataract procedure with lens implant.

Since Hsiao and his colleagues had not developed a RBRVS for this procedure, Mitchell and her colleagues at HER needed to interpolate, or estimate a value for the complex procedure. To do so, they interviewed two ophthalmologists who said that the extraction with IOL procedures took about 10% longer than the extraction without an implant and that the complexity was about the same. These two Massachusetts ophthalmologists appear to agree with HCFA, which as a result of viewing a five-minute film and from informal conversations with several ophthalmologists, concluded that the procedure with a lens implantation is not significantly more complex than a lens extraction procedure alone.

Like HCFA, we have not had an opportunity to conduct an empirically sound study of this question, and are subject to the limitations of anecdotal evidence. Our own discussions with ophthalmologists who have been performing these procedures over a number of years, suggest that the procedure that includes a lens implant is significantly more difficult and risky for the patient than a simple lens extraction. We understand, but have not had the opportunity to validate ourselves, that this difference in complexity and patient risk is reflected in differences in standard patient consent forms for the two procedures. This is, of course quite logical, since implantation of a lens in the posterior chamber where visualization is limited necessarily increases the risk of damaging the structure of the eye as contrasted with a procedure not entailing the lens implanting procedure. Our own conversations is consistent with the written statements you have received from ASCR members.

If one believes the two Massachusetts ophthalmologists with regard to the relative complexity of the extraction with implant, then, as Mitchell reports, the implant operation is 52% overpriced compared to hernia repair. If, however, the extraction plus the implant were judged "considerably" more complex than the extraction alone - 2.01 times to be exact - then the Medicare price for the extraction plus implant would be exactly appropriate, compared to a hernia repair (i.e., "cost" $475 per RBRVS point). Interestingly, this weighting would also result in a 51% greater relative value assigned to the extraction with implant, compared to the extraction alone.

Thus, by simply changing one small assumption in the RBRVS scale, we eliminate the evidence HCFA has presented that the price for lens implant surgery is "grossly excessive" compared to other surgeries, including cataract extraction alone. And to change that assumption, we merely substitute the judgments of one very small arbitrarily selected set of physicians for another. We firmly agree with the authors of the HER study that substantially more research is required.

Finally, it should be noted that HCFA both relies on and disregards the Hsiao and Mitchell studies. The strong message of those studies is that something other than "time on task" must be taken into account in evaluating the price of a medical service. And yet, HCFA in its own methodology (discussed below) and in the data from the first Hsiao study which is selectively reported, seems to argue that it is appropriate to ignore any consideration other than time on task.

In referencing findings from the first Hsiao study, HCFA states in the NPRM that "this study showed that Medicare prevailing charges in Massachusetts per surgical hour were $390 for appendectomy, $362 for cholecystectomy, $342 for hysterectomy, and $788 for lens extraction." This is cited as evidence of the grossly excessive price of lens surgery. However, when the relative complexity of the operations is taken into account, as Hsiao intends, then lens extraction comes out substantially underpriced compared to all of those operations, except for hysterectomy. This can be seen in Table 2, which we computed from data in Hsiao's study. Table 2 shows, for example, that the Medicare prevailing charge per "resource use" point was $377 for appendectomy, out only $261 for lens extraction.

. . .

Whatever one may think of HCFA's methodology (and our assessment of it) for evaluating charges for lens implants, we believe that HCFA's failure to clearly set forth measurable criteria for determining when charges are "grossly excessive" is a serious flaw. This deficiency applies not only to the case at hand, but to future rulings under the inherent reasonableness provision as well.

Cataract Surgery
Medicare Prevailing Charges, 1985
Energy and Commerce Proposal:
Add 10% to Surgery without Implant
(States ranked by average percentage loss per case)

State	Extracap W/out IOL	Plus 10%	Extracap with IOL	Dollar Loss	Percent Loss
Michigan	946	1041	2121	1080	51
Arizona	1064	1170	2155	985	46
District of Columbia	1277	1405	2500	1095	44
Nevada***	1064	1170	2068	898	43
Utah	724	796	1368	572	42
Tennessee	825	908	1538	630	41
North Dakota**	929	1022	1706	684	40
Virginia	842	926	1556	630	40
South Carolina	825	908	1500	592	39
Maryland	894	983	1586	603	38
Mississippi*	825	908	1467	559	38
Pennsylvania	984	1082	1757	675	38
Montana*	980	1078	1715	637	37
Georgia	923	1015	1596	581	36
Iowa	825	908	1425	517	36
Ohio	988	1087	1707	620	36
Texas	1031	1134	1778	644	36
Oregon	1031	1134	1756	622	35
New Hampshire	928	1021	1547	526	34
Kentucky	960	1056	1575	519	33
Massachusetts	1031	1134	1681	547	33
West Virginia	1020	1122	1679	557	33
Missouri	919	1011	1482	471	32
Oklahoma*	804	884	1309	425	32
North Carolina	750	825	1200	375	31
Louisiana	970	1067	1531	464	30
New Jersey	1119	1231	1771	540	30
Idaho	875	963	1351	388	29
Indiana	868	955	1340	385	29
Kansas	877	965	1352	387	29
Vermont	920	1012	1420	408	29
Minnesota	892	981	1366	385	28
Alabama	949	1044	1430	393	27
Washington	1003	1103	1512	409	27
Hawaii	1238	1362	1852	490	26
Florida	817	899	1166	267	23
Rhode Island	1071	1178	1532	354	23
Colorado	958	1054	1347	293	22
Delaware	957	1053	1349	296	22
Alaska	1650	1815	2305	490	21
Maine	971	1068	1360	292	21
New York	1266	1393	1742	349	20
Arkansas	978	1076	1279	203	16
New Mexico	1522	1674	1981	307	15
Wisconsin	1134	1247	1391	144	10
California	1783	1961	2100	139	7
South Dakota	1413	1554	1632	78	5

Source: "Prevailing Charges, FY 1985, Cataract Procedures," unpublished data, HCFA, HHS, 6-17-85.
Figures not available for: Connecticut, Illinois, Nebraska, Wyoming.
*Used figures for intracapsular extraction without IOL implant.
**Used figures for intracap with and without IOL.
***Used Arizona figures for extracap without IOL.

Attachment 2

STEPS IN CATARACT SURGERY

Prepared By

Stephen A. Obstbaum, M.D.
A Member of the American Society of Cataract and Refractive Surgery

1. Preparation for administration of local anesthesia

   - intravenous infusion
   - monitor for blood pressure; pulse
   - nasal cannula for administration of oxygen
   - pupil of eye to be operated is dilated

2. Administration of local anesthesia after intravenous amidate or other suitable short acting agent

   - retrobulbar or peribulbar and facial nerve injections of appropriate anesthestic agent
   - ocular compression with Honan balloon or similar device

   Goal: excellent akinesia (no ocular movement) and anesthesia (no sensation)

3. Sterile preparation and draping of the operative field

4. Insertion of lid speculum and stabilizing sutures to insure good exposure of operative field and positioning of the eye

5. Incision of conjunctiva to
   a. expose the surgical limbus
   b. insure excellent wound closure and coverage at the completion of surgery

6. Application of diatherry to cautery to surgical site
   a. achieve hemostasis (reduce risk of intraoperative hemorrhage)
   b. clean and define the area of initial incision site

7. Partial thickness grooved incision of sclera
   a. creates the initial plane of a biplaned, mortiсed incision (important in subsequent wound closure and reduction of postoperative astigmatism

8. Entry into the anterior chamber
   a. controlled incision - in plane of the iris to begin the horizontal aspect of the biplaned, mortiсed incision
   b. incision of limited size to facilitate anterior chamber maintenance while performing the anterior capsulectomy
   c. critical to avoid touching iris which might cause pupil to constrict
   d. avoid cutting the iris and/or producing a hemorrhage from the root of the iris

9. Anterior capsulectomy
   a. extremely important step in extracapsular cataract extraction
   b. must be done deliberately and precisely
   c. should be performed in a formed anterior chamber (fluid, air, viscoelastic material) [NOTE: one extracapsular cataract extraction technique uses open chamber maneuver]
   d. properly performed anterior capsulectomy facilitates both
      - nucleus delivery
      - cortical irrigation and aspiration
   e. maintenance of anterior capsule remnant and capsule bag is critical for in-the-bag posterior chamber lens implantation

10. Extending the incision into the anterior chamber
    a. for nucleus expression and/or delivery
    b. completion of biplaned configuration to facilitate later wound apposition and closure
    c. care to prevent intraocular hemorrhage from scleral vessel or iris root

12. Nucleus delivery
    a. removes central aspect of cataractous lens (alternatively can be removed by emulsification or phacoemulsification technique)
    b. care exercised to prevent - tearing of iris sphincter
                                 - disrupting of lens zonules
                                 - rupturing of the posterior capsule

    NOTE: Either disrupting the zonules or disrupting the posterior capsule can produce unwanted vitreous loss and its attendant long-term complications
    Zonules are the suspensory ligaments of the human lens
    Posterior capsule is that portion of the capsular sac that surrounds the lens that is in contact with the vitreous humor

13. Irrigation and aspiration of cortical material using mechanical or manual devices
    a. removes that portion of the lens that surrounds the nucleus and lines the capsular bag
    b. complete removal is important for postoperative optical clarity and posterior chamber intraocular lens implantation
    c. crucial to prevent disruption of zonules and/or posterior capsule rupture (as with nucleus delivery)

    NOTE: should (c) occur:

    a. a vitrectomy might be required
    b. an intraocular lens (posterior chamber) might not be implanted, although at times an anterior chamber intraocular lens could be used
    c. the incidence of postoperative complications is usually increased, ie, cystoid macular edema, retinal detachment, postoperative inflammation, glaucoma, corneal decompensation. Some of these conditions require secondary procedures and/or additional diagnostic testing and treatment.
    d. When an intraocular lens cannot be implanted the patient would have to use a contact lens and if this was unsuccessful, an aphakic spectacle.

d. Incision is closed with sutures - some permanent and some temporary - to maintain the anterior chamber to prevent complications related to the capsular bag and/or cornea

13. Preparation for intraocular lens implantation
    a. remove temporary sutures to create a space for introduction of intraocular lens implant
    b. maintain the anterior chamber: air, fluid, viscoelastic material
    c. prepare for in-the-bag implantation: widen fornices of capsular bag with a viscoelastic agent
    d. examination of intraocular lens under operating microscope:
       - proper power indication if present on optic (check package for power and size characteristics)
       - surface of intraocular lens for imperfections or debris
       - haptics: proper curvature, angulation, insertion into optic

14. Insertion of intraocular lens
    a. prevent damage to cornea, iris, and capsule by precise manipulation and control of intraocular lens, formed anterior chamber, and adequate capsular space
    b. after initial introduction of inferior loop (haptic), verify position within capsular bag
    c. insert optic into the pupillary space
    d. implant the superior loop in the capsular bag and verify its position
    e. rotate the intraocular lens into the most desirable position depending upon capsular configuration

15. Miosis of pupil (constriction) and injection of air to reform the anterior chamber
    a. miosis of pupil - covers the optic of the intraocular lens - reduces amount of light directed and focused through intraocular lens onto the retina from microscope
    b. air injection - reforms the anterior chamber to allow correct wound apposition and closure

16. Careful, meticulous wound closure
    a. reduces astigmatism
    b. reduces wound related complications, ie, wound leaking, filtering blebs, epithelial downgrowth, fibrous ingrowth, flat anterior chamber
    c. promotes immediate ambulation, return to normal activities, and visual rehabilitation

17. Removing stay sutures and reapposition of conjunctival tissue to cover the cataract incision and sutures

18. Injections: in subconjunctival-sub-Tenon's space
    antibiotic - to prevent infection
    steroid - to reduce postopertive inflammation
    Instillation of antibiotic (topical) ointment

19. Remove lid speculum - place sterile eye pad and protective shield over patient's operated eye.

20. Remove patient to recovery area - when patient's condition is stable the intravenous infusion is removed and patient is discharged from recovery area by anesthesiologist..

21. Patient taken to outpatient area where he/she is provided a snack. Clothing is changed; patient is discharged from hospital.

Attachment 3

MEDICARE REIMBURSEMENT FOR IOLS PURCHASED BY OPHTHALMOLOGISTS

Jerald A. Jacobs
Jenner & Block
ASCRS General Counsel
May 11, 1987

Cataract Society members have recently raised questions about Medicare reimbursement for intraocular lenses when the IOLs are purchased by ophthalmologists themselves, rather than by hospitals, for use in performing cataract surgery. Here are answers to those questions based upon Medicare law and policy, as well as upon informal consultations with Medicare officials.

1. Will Medicare reimburse for an IOL when purchased by the ophthalmologist rather than by the hospital?

The answer depends upon the setting of the cataract surgery.

For an inpatient cataract procedure, the Medicare prospective payment system mandates that the hospital be reimbursed one all-encompassing facility payment, under Diagnosis Related Group (DRG) 39 for cataract surgery, which includes reimbursement for the IOL used. The ophthalmologist's services in performing the cataract surgery are separately reimbursed on the basis of the "reasonable charge". The ophthalmologist is prohibited from billing Medicare for the IOL; but the ophthalmologist can purchase an IOL and sell it to the hospital.

For an outpatient cataract procedure, the hospital is now reimbursed at its "reasonable cost" for each of the services and supplies it provides, one of which can include the IOL. The ophthalmologist's services are separately reimbursed on the basis of the reasonable charge. At least currently the ophthalmologist can also be reimbursed by Medicare as the supplier of an IOL if it is not supplied by the hospital. Last year Congress directed that hospital outpatient department reimbursement be reduced or "blended" with the local ambulatory surgery center facility payment in phases beginning October 1, 1987; by October 1, 1989, a prospective payment system covering hospital outpatient departments is to be in place. Last year Congress also banned "unbundling" of hospital outpatient services and supplies -- Congress ordered that all services and supplies provided at the hospital outpatient department, other than physicians' services, be billed to Medicare only by the hospital. The supplying of IOLS is one item that will have to be billed by the hospital. Medicare plans to implement that unbundling bar as of July 1, 1987. Thus currently the ophthalmologist who supplies an IOL for use in a hospital outpatient cataract procedure can be reimbursed for the IOL; but after July 1 the ophthalmologist will be prohibited from billing Medicare for the IOL. Then as now, however, the ophthalmologist will be able to purchase an IOL and sell it to the hospital.

For an ambulatory surgery center (ASC) cataract procedure, the ASC is reimbursed a flat facility payment. The ophthalmologist's services are separately reimbursed on the basis of the reasonable charge; at least currently the ophthalmologist can also be reimbursed as the supplier of an IOL. Last year Congress directed that the flat facility

payment to ASCs be updated by July 1, 1987. Medicare has not yet determined whether at some future date it might ban unbundling for ASCs -- i.e. whether it will include IOL reimbursement in the flat facility payment to the ASC and prohibit an ophthalmologist who performs cataract surgery at the ASC from billing Medicare for the IOL.

2. At what rate does Medicare reimburse for the IOL when it is purchased by the ophthalmologist?

Ordinarily, Medicare carriers have treated IOLs as other prosthetic devices and have based IOL reimbursement on the reasonable charge for the devices. But in October, 1985, after Congressman Pepper issued his report on "Cataract Surgery: Fraud, Waste and Abuse", the government suggested that Medicare carriers should review IOL reimbursement rates to determine if they are "inherently reasonable". The Medicare agency noted that "reasonable charge allowances for IOLs are grossly disproportionate to the acquisition costs." The agency advised carriers, in setting IOL rates, to consider the acquisition cost and possibly a handling or dispensing fee; but it warned that ophthalmologists are already reimbursed for performing cataract surgery and should not be allowed retail "markup" levels for IOLs. Later it was clarified that differences among types of IOLs and special patient needs might also be considered. Medicare has recently reminded the carriers to conduct inherent reasonableness reviews of IOL reimbursement. If changes are to be made, the carriers must now notify and seek comments from those affected.

An IOL manufacturer-commissioned survey found that Medicare carriers have not reacted uniformly to the direction from the government on IOLs. Carriers in about half of the states report that they continue to reimburse the reasonable charge for IOLs supplied by ophthalmologists, subject to a maximum allowable limit, which is often well in excess of current typical acquisition costs for most IOLs. These carriers have apparently not changed their methodologies or rates as a result of inherent reasonableness reviews. Carriers in the other half of the states appear to be using the acquisition cost, i.e., the manufacturer's invoice amount, as the basis for IOL reimbursement when the IOL is supplied by an ophthalmologist. Many of those carriers require that a copy of the invoice be submitted with an IOL claim; many of them also permit a handling charge in addition to the lens acquisition cost. Another manufacturer-commissioned survey in 1986 found that the average handling expense when an IOL is purchased by an ophthalmologist is $54.46. Carriers that have modified the prosthetic device reasonable charge methodology for ophthalmologist-supplied IOLs seem most often to reimburse the invoice amount plus a reasonable handling charge, with the entire IOL reimbursement limited to a maximum amount. This may be the approach most favored by the government since it includes an incentive to limit acquisition costs for IOLS.

In short, there is little uniformity in carriers' reimbursement rates for IOLs purchased by ophthalmologists. Not all carriers have changed from the conventional reasonable charge methodology to an essentially cost-based methodology as a result of the inherent reasonableness reviews suggested by the Medicare agency in 1985.

3. Is it legal for an ophthalmologist to make a profit when supplying IOLs?

If an ophthalmologist is in an area where the Medicare carrier neither requests nor requires any

information or documentation from the ophthalmologist on the IOL acquisition cost, but reimburses an amount that is higher than the acquisition cost, the ophthalmologist is likely within the law in making whatever IOL profit is the result.

There are, however, three important considerations before concluding that Medicare profits from supplying IOLs are without legal risks to the ophthalmologist.

First is the risk of making false claims. If the ophthalmologist is in an area where the acquisition cost is requested or required for use in the carrier's IOL reimbursement rate determination, any explicit or implicit withholding or falsification by the ophthalmologist of cost information or documentation would likely violate several Medicare law provisions as well as other federal or state laws. The outright denial or changing of this data is obviously improper. But, for example, if ophthalmologists establish their own "distributing company" to acquire IOLs and sell them back to the ophthalmologists in order to secretly inflate the acquisition costs requested or required by the Medicare carrier, this would almost certainly violate the law as well.

Second is the risk of violating the Medicare "fraud and abuse" provision. This law prohibits the requesting, receiving, offering or paying of any "remuneration" to refer someone to Medicare-reimbursed services or goods or to induce someone to buy, use or recommend Medicare-reimbursed services or goods. Prohibited remuneration includes kickbacks, bribes or rebates; the remuneration is illegal whether it is direct or indirect, overt or covert, in money or anything else of value. The only exceptions are: (1) discounts or price reductions that are disclosed and reflected in Medicare claims, no matter who files the claims; and (2) arrangements between actual employers and employees. Violations of the law are criminal felonies. Penalties include fines up to $25,000 and 5 years in jail.

This provision is very broad. It has been interpreted very strictly.

A deliberate kickback, bribe or rebate in any form made by a manufacturer to an ophthalmologist in connection with IOL purchases is a felony for both the manufacturer and for the ophthalmologist. Not only are direct payments prohibited, but so are any free or reduced-cost items or services provided by the manufacturer and any unjustifiably high fees such as for serving as a manufacturer's consultant, speaker or investigator if the payments, items, services or fees are intended to encourage the ophthalmologist to purchase particular IOLs or to ask a hospital to purchase them. Again, the only exceptions are when there is a discount or price reduction that is disclosed and reflected in the Medicare claim or when the arrangement is between an employer and an employee.

There is no official interpretation of what constitutes, in the words of the law, a "discount or other reduction in price" that must be "properly disclosed and appropriately reflected" in a Medicare claim to qualify for the exception and avoid its being considered an illegal referral or inducement fee. For IOLs purchased by an ophthalmologist, there may be an absolute, affirmative obligation under criminal law to disclose and reflect in Medicare claims any special or negotiated reductions in IOL acquisition costs below list prices, catalog prices, regular

prices, normal prices, or market prices even if acquisition costs are not sought or required by the carrier.

The presence of discounts or price reductions to be disclosed and reflected in Medicare claims may be indicated when the ophthalmologist is able to purchase IOLs in a large volume, or over a long-term period, or under stipulated conditions that result in the per-lens cost being lower than if a single IOL were purchased. It is noted again, though, that there has been no official interpretation of this issue.

One thing is very clear. The Medicare fraud and abuse provision is sweeping in its scope and severe in its penalty. It must not be disregarded in evaluating the legality of ophthalmologists' profits on IOL purchases.

Third is the prospect of ethical or malpractice risks. Several national and local medical organizations promulgate ethical codes that circumscribe or prohibit the dispensing by physicians of pharmaceuticals or medical devices when one purpose is financial gain. The concern is that a physician's medical judgment as to what is in the patient's best interest could be compromised if the physician also seeks profits from dispensing. An ophthalmologist who obtains unreasonable profits from Medicare reimbursement of IOLs might be found to have violated those codes.

Under the same theory, evidence of substantial profits from reimbursement for IOLs could be an important factor in the determination of liability in a malpractice case against an ophthalmologist. The existence of a strong profit motive on the part of an ophthalmologist accused of inadequately caring for a patient could likely be devastating to that ophthalmologist's successful legal defense.

Since there are variations in both ethical codes and malpractice law, it is impossible to assess generally the extent of risk in these areas from ophthalmologists' profits on IOLs. But again that risk cannot be ignored.

4. After July 1, when only the hospital can bill Medicare for reimbursement as the supplier of an IOL used in hospital outpatient cataract surgery, can an ophthalmologist nevertheless profit by purchasing the IOL and selling it to the hospital with a mark-up?

There is no direct violation now, and none is likely to be imposed, if an ophthalmologist sells IOLs to a hospital where the ophthalmologist is precluded from being reimbursed by Medicare as the supplier of IOLs because of an unbundling ban. In this arrangement, the ophthalmologist would purchase IOLs from a manufacturer and sell them to a hospital, presumably at a profit; and the hospital would be reimbursed by Medicare as the supplier of the IOLs.

While not strictly prohibited, however, this practice is fraught with potential problems.

From the point of view of Medicare policy, the practice would indirectly thwart the Congressional ban on unbundling of services and supplies provided at a hospital that is in effect now for inpatient procedures and takes effect July 1 for outpatient procedures. Hospitals are required to be "prudent purchasers" of that for which Medicare reimburses. A hospital could risk its own status in the Medicare program if it were to knowingly facilitate unreasonable profits on IOLs by ophthalmologists.

At the practical level, where the hospital is reimbursed in whole or in part a flat facility fee for the services and supplies it provides in connection with cataract surgery, including the IOL, the hospital has a strong incentive to pay the lowest possible price for the IOL, without paying an unnecessary mark-up to the ophthalmologist. Ordinarily IOLs can be purchased directly from manufacturers. It is logical and likely that a hospital can achieve higher volume discounts than a single ophthalmologist.

As to the legality of a hospital buying IOLs from an ophthalmologist at a mark-up, the Medicare fraud and abuse provision could be a strong deterrent. If a hospital is found to be paying an ophthalmologist a higher price for IOLs than the price that the hospital itself can readily obtain from the IOL manufacturer, there is an implication that the profit paid to the ophthalmologist is intended to encourage the ophthalmologist to perform cataract surgery at the hospital. Any such referral fee could be a felony violation by both the hospital and the ophthalmologist under the Medicare fraud and abuse provision.

It is anticipated that only hospitals will be purchasing and billing for IOLs in virtually all hospital-based cataract surgery for Medicare patients after July 1.

Mr. COYNE. Thank you, Dr. Dodick. The next panelist is Dr. Cooper.

STATEMENT OF REGINALD COOPER, M.D., PRESIDENT, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Dr. COOPER. I am Reginald Cooper, president of the American Academy of Orthopaedic Surgeons, a practicing orthopedist, and chairman of the department at the University of Iowa. I appreciate this opportunity to come and comment to this committee.

While we appreciate the need for savings, a reduction in the Federal deficit, and the need to address unreasonable geographic variations and charges, I can assure you that our academy, representing 12,000 board-certified orthopedic surgeons will not abdicate its role as advocate of the patient, and in assuring that quality musculo-skeletal care continues.

Mr. Chairman, we believe that the Physician Payment Review Commission has an important role to play in recommending improvements in the Medicare payment system. We are concerned, however, that the involvement of the Commission in the formulation of options to meet short-term budget savings is a diversion of the Commission's mission of long-term mission reform.

We are extremely concerned about their limited time and resources, and would hope that any short-term recommendations would indeed be consistent with long-term revisions in the payment system.

In a brief review of their three options, we are extremely concerned about the hasty development of a relative value scale for the express purpose of identifying outlier procedures as described by the committee staff proposal.

Any such scale has to be very carefully considered, so that it does not institute a methodology that is unfair to both the patient and the physician. Simply taking the top ten procedures, in terms of volume, or dollars spent, and arbitrarily decreasing payment for them, has many, many flaws.

These procedures may be, and in fact probably are, very critical to the health and maintenance of a quality of life for the Medicare population. The ability for the older person to see, to go to the bathroom, to be able to walk, and to have a functioning cardiovascular system are obviously critical items.

Thus, a hastily constructed scale that would automatically decrease payment for such procedures seems contrary to the long-term goals of the Commission.

The much-emphasized Hsiao resource-based RVS constructed in 1985, and which is going to be modified for the Congress and HCFA in the next year or two, by the admission of the author, can range up to 25 percent in error, in individual values.

In general, we also believe that a resource-based RVS does not adequately account for such service factors as efficacy, the value of services to the patient, complexity and severity, market factors, risk benefit, and technical sophistication.

We question several aspects of such a relative value scale. Specifically, the Hsiao study was developed in part to address what we

consider an artificial, misleading, and potentially harmful distinction between so-called cognitive versus procedural services.

In addition, we seriously question the degree to which physicians in each discipline are going to have meaningful input into a relative value scale. We have heard today about many of the problems of a relative value scale, and I would also point out, that in looking at the chart that was handed to you, unless we know about the conversion factors for those relative value scales, we really do not know what the costs are.

I would also emphasize that it is extremely difficult to compare one procedure to another across specialty lines. A reduction in the Medicare Economic Index might target one segment of the physician population in a cost-containment adjustment, and may render those physicians indefensible against inflation and skyrocketing professional liability premiums.

I think that you have heard enough about the new physician option. I do not think it deserves further comment.

Specifically, we would offer the following options, which may help you save in the short-term, specifically in fiscal year 1988. We believe that careful consideration should be given to a proposal such as that by the American College of Surgeons, to limit payment on a State-by-State basis.

This should address the issue of geographic variation in fees, some of which obviously cannot be explained by practice costs and living costs. It might be also valuable, over the short-term, to pay no more than a certain percentage above the national average for a given procedure.

Second, collapsing codes, or at least defining standardized units within a given code, seems to be most reasonable. Certainly, for the top procedures in terms of volume and costs, one could define a standard bundle, and obtain data on the abuse of the system by unbundling.

Third, short-term savings could be realized by adopting a set of criteria for reimbursing assistance at surgery, predicated upon the condition of the patient and the nature of the operative procedure. I would also echo what my colleague just told you about more stringent monitoring of fraud and abuse of the system. That is certainly in order.

Fifth, the present review should include, in our opinion, evaluation of the need and effectiveness of office, home, and hospital visits by physicians, as well as care provided by nonphysicians.

Any or all of the above, we believe, would serve as a reasonable, orderly, interim series of steps to a major reform of physician payment under Medicare.

This concludes my remarks, and again, I thank you for the opportunity of addressing your subcommittee.

[The statement of Dr. Cooper follows:]

Statement

of the

American Academy of Orthopaedic Surgeons

Mr. Chairman, and members of the Committee, I am Reginald Cooper, President of the American Academy of Orthopaedic Surgeons, a practicing orthopaedist, and Chairman of the Department of Orthopaedic Surgery at the University of Iowa.

We appreciate this opportunity to comment on the various options proposed by the Physician Payment Review Commission's staff to achieve savings under the Medicare program. We will comment, in our oral testimony on the specific recommendations proposed by the Physician Payment Review Commission, which were not available at the time this statement was prepared.

One of the primary beliefs of the Academy, as the voice of over 12,000 Board certified members, is to assure that patients have access to the best orthopaedic care possible at an affordable price. While we appreciate the need for savings, a reduction in the federal deficit, and the need to address unreasonable geographic variations in charges, I can assure you that this specialty will not abdicate its role as an advocate of the patient in issues which could erode quality patient care.

Mr. Chairman, we believe that the Physician Payment Review Commission has an important role to play in recommending improvements in the efficiency and effectiveness of Medicare services and in establishing valid mechanisms to control the overall cost of the program. We are concerned, however, that the involvement of the Commission in the formulation of options to meet short term budget savings is a diversion of the Commission's mission of long term system reform. Moreover, it is our view that given the Commission's limited resources it is not in a position to adequately assess the impact of the various savings proposals on patients and physicians.

We are, in general, extremely concerned about the hasty development of a Relative Value Scale for the express purpose of identifying "outlier" procedures as described in the Commission's staff proposal. Any such scale has to be carefully considered so that it does not institute a methodology that is unfair to both the patient and physician. Simply taking the top 10 surgical procedures in terms of volume or dollars spent and arbitrarily decreasing payment for them would seem to contain many flaws.

These procedures may be very critical to the health and maintenance of a quality of life for the Medicare aged population. The ability for the older person to see, to go to the bathroom, to be able to walk, and to have a functioning cardiovascular system are obviously critical items. Thus, a hastily constructed Relative Value Scale that would automatically decrease payment for such procedures seems contrary to the goals outlined in the Commission's March 1987 report and, more importantly, could require a major effort twelve months from now to revise a flawed system instituted in the name of short-term savings.

In reviewing the three options proposed by the Physician Payment Review Commission's staff in its May 14, 1987 letter, we have the following specific comments:

1. An "inherent reasonableness" option that would reduce prevailing charges for a list of procedures regarded as outliers. We have a number of concerns about the state-of-the-art of Relative Value Schedules currently being examined.

   First, the much emphasized Hsiao resource-based RVS as constructed in 1985 and which is an RVS used by the staff to identify "outliers", is subject to error in the range of 25% for individual values, according to testimony given Dr. Hsiao before the Commission. We also wish to point out that the work done by Hsiao and his colleagues in 1985 revealed that cholecystectomy was undervalued by 16 percent under Medicare payment in Massachusetts. Thus, relative payments higher than that for cholecystectomy should not be construed to be necessarily overvalued.

   In general we believe that a resource-based RVS does not adequately account for such factors as efficacy, the value of the services to the patient, and complexity or severity. Moreover, we question several aspects of the Hsiao study which was developed in part to address what we consider an artificial, misleading, and potentially harmful distinction between so-called cognitive versus procedural services. In addition, we seriously question the degree to which physicians in each discipline have been involved in the development of a meaningful RVS.

   Second, the inclusion of the Ontario fee data to identify "outliers" is inappropriate since the Canadian health care system differs markedly from ours. To utilize Ontario data for a few surgical fees takes them entirely out of context of payment for all services.

   Third, much work needs to be done to determine the correct factors to be considered for the construction of a Relative Value Scale. This is certainly supported by the data supplied by the PPRC staff which showed five Relative Value Scales with wide variations in value when compared to each other.

   For example, in the staff proposal the RVS listed as insurance company #2, used a panel of physician specialists to make judgements about the complexity and severity of various procedures as well as the time and skill required, closely matches the Medicare RVS listed on the same table. Although there is some small variation in values between insurance company #2 RVS and the Medicare RVS, one wonders if the gap would be closed if the company's panel of physician specialists were asked to consider age as a factor.

We are very concerned about this committee making a series of decisions based upon a Relative Value Scale which considers time alone or resource consumption alone without considering complexity and severity, market factors, risk, benefit, technical sophistication required, and without much input from specialists in various fields. Only by considering all of these factors can a specific Relative Value Scale serve as the best one for beneficiaries, physicians, and taxpayers.

Mr. Chairman, we believe this Committee has a responsibility to Medicare beneficiaries to be certain that the actions taken in the name of fiscal year 1988 budget savings will not be so precipitous as to dimish access to services. Your actions to achieve cost reductions must be rationally, equitably, and actually related to the medical values of the services provided. As you consider "Relative Value" we believe you must look further than a few surgical procedures.

2. A reduction in the amount by which prevailing charges are updated by the Medicare Economic Index. To single out surgeons in an MEI adjustment would render them indefensible against inflation. To target one segment of the physician population in a cost containment adjustment would be extraordinarily narrow. The MEI, which we believe contains certain flaws and does not reflect changing practice costs, must be applied to all physicians and adjusted to accurately reflect geographic and other resource requirements necessary to the practice of medicine. The surgical procedures identified as "outliers" are considered high risk procedures by both the practitioner and insurance carriers. As such most orthopaedic surgeons are faced with skyrocketing professional liability insurance premiums. In fact, in some areas of the country premiums exceed $90,000 per year.

3. The "new physicians" option proposed in the President's Budget. Changing the entry level payment for a new physician is unfair. This places a disproportionate burden on those least able to bear the brunt of income reduction. New practitioners have substantial education debt, face high start-up costs, have escalating malpractice premiums and a low patient volume. This short term solution could engender long term problems wherein young physicians abandon rural areas for affluent practice settings or join large groups; thus limiting access to quality care by certain segments of the Medicare population.

We understand the difficult task facing this Committee, namely to come up with budget savings for fiscal year 1988, and as such we offer the following options:

1. We believe careful consideration should be given to the proposals by the American College of Surgeons to limit payment on a state-by-state basis. This should address the issue of geographic variation in fees, some of which

obviously cannot be explained by practice costs and living costs. It might also be valuable over the short term to pay no more than a certain percentage above the national average for given procedures.

2. Collapsing codes or at least defining standardized units within a given code seems to be a reasonable procedure for short term savings. Certainly for the top procedures in terms of volume and costs, one could define a standard "bundle" and obtain data on the abuse of the system by "unbundling".

3. Short term savings could be realized by adopting a set of criteria for reimbursing assistants at surgery predicated upon the condition of the patient and the nature of the operative procedure.

4. More stringent monitoring of fraud and abuse of the system is certainly in order.

5. The present review should include evaluation of the need and effectiveness of office, home, and hospital visits by physicians, as well as care provided by non-physicians.

On this last point Mr. Chairman, we reviewed the mid-year 1985 Medicare expenditure estimates. Of the twenty most frequent services, thirteen, totaling $3.3 billion were for follow-up office or hospital visits, or for office visits to non-medical providers. Of this amount, over $2 billion is for services identified as brief, minimal, or limited office or hospital visits.

We believe this large expenditure should be included among the options you consider. Moreover, we believe that this Committee must develop mechanisms to determine if the patient is receiving a health benefit equal to the public dollars being expended. You must ask what truly makes a difference in longevity and the quality of life for our senior citizens? Moreover, we urge the Congress and the Administration to undertake a timely evaluation of Medicare services in order to determine if the millions spent on procedures and services of questionable scientific value deliver value for the medical dollar.

Any or all of the above would serve as reasonable and orderly interim steps prior to a major reform of physician payment under Medicare. We believe that the input of speciality societies such as ours could be of help as you continue your quest to develop an equitable system which will continue to provide high quality health care for Medicare beneficiaries.

That concludes my remarks. I will be happy to answer any questions.

Mr. COYNE. Thank you, Dr. Cooper. Dr. Albers.

STATEMENT OF JOHN E. ALBERS, M.D., CHAIRMAN, GOVERNMENT RELATIONS COMMITTEE, SOCIETY OF THORACIC SURGEONS AND THE AMERICAN ASSOCIATION FOR THORACIC SURGERY

Dr. ALBERS. Mr. Chairman, members of the committee, I appreciate the opportunity to appear before you on behalf of the Society of Thoracic Surgeons and the American Association for Thoracic Surgery. I am John Albers, M.D., a board-certified thoracic cardiovascular surgeon, practicing and teaching in Cincinnati, Ohio.

I am also chairman of the Joint Government Relations Committee of the Society of Thoracic Surgeons and the American Association for Thoracic Surgery, and a member of the technical advisory committee for thoracic cardiovascular surgery to the resource-based relative value scale study being conducted by Professor Hsiao and his colleagues at the Harvard School of Public Health.

I have been a practicing surgeon for over 20 years.

Mr. Chairman, we recognize that the current usual, customary, and reasonable Medicare physician payment system is arbitrary, overly complex, outdated, and in need of reform.

This raises two obvious questions. If the current system of payment is flawed, what will we put in its place; and second, what short-term measures should be taken to meet budgetary targets which are compatible with long-term reform?

The Physician Payment Review Commission has recommended to Congress several options. Option 1 is a reduction in the amount by which prevailing charges are updated by the Medicare Economic Index.

This is an across-the-board approach which in effect unjustly, and seriously affects, the conscientious and judicious-charging physicians, and continues to reward the more aggressive-charging physicians by sanctioning the charge profiles now in effect in their areas.

I do not think this is the lesson of expediency which Congress wishes to send to the physicians of our country. A more positive approach would be to address the wide variations in regional fees which now exist, not only from one State to another, but within the same State.

Some variation has to exist to account for differences in cost of practice, cost of living, cost of liability insurance from one region to another, but these variations should not be nearly as great as today.

The American College of Surgeons has recently recommended that payment should be limited to no more than a clearly defined percentage above the average State or national level.

The thoracic societies support this proposal. We would prefer to see a system based on weighted national average fees, taking the appropriate time to do it rationally and correctly.

I understand that HCFA states it does not now have the data from the carriers on which it could calculate the national average reimbursement for coronary artery bypass surgery.

We find it inexcusable that this data cannot be obtained quickly. Certainly, we would not accept this from a private corporation which did not know what it was paying for its supplies, or could not obtain this data, and bring its costs under control in a very short period of time.

The thoracic societies, if permitted and financed, could come up with this in a relatively short time by polling our members.

We also strongly support the bundling of charges for surgical procedures, ending payments for fragmentary charges.

Option 2. An "inherent reasonableness" option that would reduce prevailing charges for a list of procedures regarded as outliers, and be subject to across-the-board cuts based on comparison between the value scales implicit in Medicare reimbursement in four States, value scales used by private payers, and the earlier Massachusetts RVS study.

The validity of using only data from four States is very questionable, and Dr. Hsiao himself has admitted that the Massachusetts' study could be off by as much as 25 percent. For reasons stated earlier, we are opposed to across-the-board cuts because of their inherent unfairness. Those who charge reasonably should not be penalized.

The changing difficulty and complexity of coronary artery bypass surgery between today, and 5 or 10 years ago, raises doubts about the validity of using these older RVS as the basis for payment reform.

The increased complexity of coronary artery bypass surgery on the Medicare patient also raises questions about the utility of any RVS developed on the basis of treating the average patient.

The 65-plus-year-old coronary artery patient differs greatly from the 40-year-old bypass patient. The 65-year-old has more generalized arteriosclerosis, or hardening of the arteries, kidney problems, gastrointestinal disease, and pulmonary diseases.

Dr. Roper stated something about 2 hours being the time to do a coronary artery bypass surgery. It would be more correct to state that it is in the vicinity of 4½ to 5 hours.

These multisystem organ involvements, besides the cardiac problems, increase the risk, increase the stress on the surgeons, increase the complexity and length of time to perform the procedures, and demand more professional talent. We are also performing more repeat coronary bypass operations on Medicare patients. A 20 percent incidence in individuals who had their original surgery 5 to 10 years previous.

The repeat procedures are again that much more involved in all the factors just mentioned. There is also an increased incidence of emergency surgery following attempted angioplasties, medical attempts at dissolution of clots, status angina, and postmyocardial infarction angina.

An RVS designed for average patients should be modified or recalculated to recognize these differences. Tomorrow, I will be attending a meeting of the advisory technical panel to the Harvard study of a resource-based relative value scale.

We believe that it would be a mistake to base decisions on existing outdated RVSs, prior to completion of the Harvard study, and

careful review of both its conclusion and the policy consequences of using it to reform physician payment.

I cannot emphasize this more strongly to you. In summary, we support first, a positive approach addressing the wide variation of fees in different localities. Two, any short-term measures which are taken to meet budgetary targets must be compatible with long-term reforms.

Three, await the careful and deliberate study of the resource-based relative value scale which Dr. Hsiao and his colleagues are conducting. Their work argues against hasty conclusions that one or another procedure is overvalued based on relative value scales developed with far less sophisticated techniques.

The Society of Thoracic Surgeons and the American Association for Thoracic Surgery are prepared to work with you, and the Health Care Financing Administration, as we have in the past, to prepare a satisfactory solution to these problems.

Thank you for the opportunity of presenting this testimony.

[The statement of Dr. Albers follows:]

Testimony of John E. Albers, M.D., FACS, on behalf of the Society of Thoracic Surgeons and the American Association for Thoracic Surgery before the Health Subcommittee of the House Ways and Means Committee, June 15, 198

Mr. Chairman, members of the Committee, I am happy to appear before you on behalf of the Society of Thoracic Surgeons and the American Association for Thoracic Surgery. I am John E. Albers, MD, FACS, a thoracic surgeon in private practice in Cincinnati, Ohio. I am Chairman of the Government Relations Committee of the Society of Thoracic Surgeons and the American Association for Thoracic Surgery. I am a member of the technical advisory committee for thoracic surgery to the Resource-Based Relative Value Scale Study being carried out by Professor Hsiao and his colleagues at the Harvard School of Public Health. I have been a practicing thoracic surgeon for over 10 years.

Mr. Chairman, we share the view that the current "usual, customary, and reasonable" Medicare physician payment system is arbitrary, overly complex, outdated, and in need of reform. The Medical Economic Index, placed on top of this UCR system in 1972 to correct what many saw as an inflationary bias, has had the negative effect of locking into place the inequities built into the system as it evolved in the early years of Medicare. This raises two obvious questions: if the current system is flawed, what should we put in its place; and second, what short-term measures should be taken to meet budgetary targets which are compatible with long-term reform?

In its Medicare budget proposals for the next fiscal year, the Administration, under "Administrative Action", has called for reductions in allowed charges for undefined "over-priced" procedures using the "inherent reasonableness" authority. As you know, the Sixth Omnibus Budget Reconciliation Act carefully spelled out the procedures the Secretary of the Department of Health and Human Services is to use in providing for an increase or decrease in reasonable charges. These include:

(I) Prevailing charges for a service in a particular locality are significantly in excess of or below prevailing charges in other comparable localities, taking into account the relative costs of furnishing the services in the different localities.

(II) The marketplace for a service is not truly competitive because of a limited number of physicians who perform that service.

(III) There have been increases for a service that cannot be explained by inflation or technology.

(IV) The charges do not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs.

(V) The prevailing charges for a service under this part are substantially higher or lower than the payments made for the service by other purchasers in the same locality.

SOBRA further specified that in applying these criteria, the Secretary could consider "the charges and resource costs for related procedures" and the "charges and resource costs for the procedure over a period of time."

Obviously, such changes should not be made arbitrarily. In developing regulations to implement the authority, the Health Care Financing Administration quite properly committed to publish in the Federal Register any proposed "special reasonable charge limit" before the limit is adopted and to solicit comments. Any such action should be taken only after careful thought and a review of alternative proposals to achieve an equitable result.

Representatives of the Society of Thoracic Surgeons and the American Association for Thoracic Surgery have met several times in recent years with staff of the Health Care Financing Administration

who are studying changes in the resource costs -- principally the operating room time required -- and the allowed charges for pacemaker insertions and coronary artery by-pass surgery between base periods and more recent periods. We made several recommendations on the procedures to be used, which we thought should help HCFA with its analyses. We are submitting for the record of these hearings the recommendations we made to HCFA concerning the study of pacemakers in a May, 1985 meeting with HCFA and again in a letter of June, 1986 to Mr. Henry Desmarais.

We look forward to working with HCFA and with the Congress in reviewing the conclusions of these studies and any recommendations which may grow out of them. In each case, the purpose of the study has been to compare changes in the length of time required in the operating room with trends in Medicare allowed charges between the time the procedure came into use and today. Have surgeons become more productive; has the average complexity of a case been reduced; has the technology made the procedure easier to perform than when first introduced? If so, it is reasonable to expect that at least part of the increased productivity savings should accrue to the Medicare program.

Unfortunately, it is not necessarily true that surgical procedures become easier to perform over time. Technology may become more complex as medicine advances. Changes in patient mix or changes in alternate treatments for the same medical condition may mean that a surgical procedure becomes more difficult rather than less difficult. In the case of pacemakers, the average time required in surgery has undoubtedly been reduced in the last fifteen years. However, the advent of far more complex multi-chambered pacemakers means that the amount of time required in consultation with the patient and the referring physician prior to implantation has increased.

In the case of coronary artery by-pass surgery, we have clearly experienced an increase in complexity and difficulty in recent years. We are now performing these procedures on patients considerably older than those we operated on even five years ago. In many, and particularly in Medicare patients, coronary artery disease is more advanced. Many simpler cases are being treated, at least initially, by balloon angioplasty and newer medications, and surgery is called for only after angioplasty or medical treatment has failed or lesions have recurred. We are also now more often performing repeat operations, which take longer and are much more difficult technically. These more extensive procedures are also manifestations of older patients with more advanced disease. Even surgeons who have not practiced recently may not be aware of the difficulty and complexity involved in performing this surgery on Medicare-aged patients, while maintaining low rates of mortality and morbidity. We are submitting for the record a recent abstract in the Journal of the American College of Cardiology on the "Changing Profile of the Coronary Bypass Patient". Several other reports have been presented at scientific meetings and are awaiting publication.

The staff of the Physician Payment Review Commission recently suggested that certain surgical procedures should be considered "outliers" and subject to across-the-board cuts based on comparison between the value scales implicit in Medicare reimbursements in four states, value scales used by certain private payers, and the earlier Massachusetts RVS study. This analysis of Medicare rates, based on only four states, may not be representative. Professor Hsiao has said that the Massachusetts study could be off by as much as 25 percent. We have not been able to examine the relatively few RVS used by these private payers. The analyses are subject to sharp variations depending on the index procedures selected. We are enclosing for the record a technical analysis of the PPRC staff inherent reasonableness proposal submitted previously to the PPRC by the American Medical Association.

The concerns I made earlier about the changing difficulty and complexity of CABG surgery between today and five or ten years ago, should raise doubts about the validity of using these older RVS as the basis for payment reform. The increased complexity of by-pass surgery on the older patient also raises questions about the utility, for determining Medicare reimbursement, of any RVS developed

on the basis of treating the average patient. An RVS depends upon comparisons between procedures. An appendectomy for the Medicare-aged patient is somewhat more difficult and time-consuming than an appendectomy on a thirty or forty year old patient. A general physical or internal medicine review has a greater likelihood of finding illness. But the seventy year old coronary artery patient differs greatly from the forty year old by-pass patient. If this is a repeat or an emergency intervention, such as an operation following a failed angioplasty, difficulties multiply. An RVS designed for average patients should be modified or recalculated to recognize these differences before it is used for Medicare.

Let me turn to the Harvard study of a Resource-Based Relative Value Scale. Thoracic surgeons are included in the technical advisory panel which is advising Professor Hsiao under the HCFA contract with the Harvard School of Public Health. I will be attending a meeting of the technical panel at Harvard this week. We are not opposed to the development of an RVS which could guide both HCFA and private payers in payment decisions. We believe, however, that it would be a mistake to base decisions on existing outdated RVS's -- developed from a different patient mix -- prior to completion of the Harvard study and careful review of both its conclusions and the policy consequences of using it to reform physician payment. And we are should not make important decisions based on the earlier Massachusetts study, which Professor Hsiao has said could be inaccurate by as much as 25 percent.

Certainly it would be a tragic error to single out a selected number of procedures, based on preliminary information, and then arbitrarily cut back reimbursement "across the board" for <u>all</u> physicians who perform those procedures. Quite apart from errors that might be made in selection of procedures, this action would target physicians who have been reasonable and modest in their charges as heavily as those who might be presumed to have charged excessively. Ironically, reducing all charges by the same percentage would reward those physicians who have most aggressively built their own customary charge profiles or who practice in localities where the allowed charges, for whatever reason, were already among the highest at the time the MEI was first adopted by Congress. I do not think this is the lesson of expediency which Congress wishes to send to the physicians of our nation.

We do not wish to defend, and I hope you do not wish to perpetuate, the <u>wide variations</u> in regional fees which now exist, both within thoracic surgery and within most medical specialties. While regional variations in fees may have been needed to launch the Medicare program in 1968, such large variations are indefensible today. Permitting allowed charges to rise according to the percentage-based MEI has made the discrepancies worse. Fees have risen most rapidly in those areas which already had the highest allowable charges. Some information indicates that the prevailing charges for coronary artery by-pass surgery vary from one state to another by a factor of over 2.5 to one. Other procedures reflect variations up to 4.5 to one. This is illogical and should not be allowed to continue in a federally-funded program. Smaller variations can be accounted for by differences in costs of practice, costs of living and costs of liability insurance from one region to another. But these variations should not be nearly as great as today.

Where these wide variations in geographical rates discourage new physicians from practicing in medically-underserved areas, some of the lower rates should be raised toward the national average. But that is an issue for another day. We face budgetary pressures to reduce, not to adjust. The American College of Surgeons has recently recommended that payment should be limited to no more than a clearly defined percentage above the average state or national rate. The Society of Thoracic Surgeons and the American Association for Thoracic Surgery support that proposal.

We would prefer to move as rapidly as practical to a system based on weighted national average fees. We understand that the Physician Payment Review Commission tentatively endorsed this proposal at its meeting in April but that the staff later concluded that the proposal could not be implemented in time for this year's

budget reconciliation. That is not a very good reason. First, if development and implementation of sound reform will take more time than is available between now and the beginning of the next fiscal year in October, we should take that additional time and do it correctly, properly and appropriately. Second, the option suggested by the American College of Surgeons, that this process begin with limitations on variations in reasonable charges within states that have multiple localities, provides a starting point. The variations in coding which make early implementation of this proposal difficult on a national scale do not prevent implementation at the state level.

We also strongly recommend that the services included in a basic surgical "bundle" be standardized and that separate payments for services which should be part of the surgical bundle be ended. Fragmentary charges are sometimes approved by carriers for services and medical supplies used in surgery which should be included in the basic surgical package. In some cases, coding and definition of the basic surgical package may be complex. In other cases, it should be obvious that fragmented charges should not be paid in addition to the surgical fees. STS and AATS are prepared to work with the subcommittee of the Physician Payment Review Commission set up to examine this issue and with the Health Care Financing Administration to define the proper surgical bundle for thoracic procedures, including CABGs and pacemaker insertions, in time for implementation in FY 88.

I would like to offer several further observations on the study of the Resource-Based Relative Value Scale now being conducted at Harvard. We have been impressed with the care with which Dr. Hsiao and his associates are developing and conducting the study. Nonetheless, this approach is extremely complicated. Important factors include determining the complexity of a procedure and the degree of stress which a practitioner experiences. These factors are very important to development of an RVS, but they will not easily be quantified in a "resource-based" study. Ratings of these factors are being made by respondents within their own specialties. While this may be valid within each specialty, it does not tell us how relative values will be transferred from one specialty to another. Despite these open questions, the careful and deliberate pace with which Dr. Hsiao and his colleagues are conducting their work argues against hasty conclusions that one or another procedure is overvalued based on relative value scales developed with far less sophisticated techniques.

Mr. Chairman, coronary artery by-pass surgery remains a complex and difficult procedure. We are performing this surgery on patients whose lives are, for a significant time period, sustained on heart-lung machines. The patient's life is, quite literally, in the hands of the surgical team. Thoracic surgeons have seven years of residency training after medical school and are typically in their thirties before they begin practice. The working life of a thoracic surgeon will often be shorter than that of many other physicians. These are all factors to be taken into consideration in developing an RVS for thoracic surgery.

In the context of short-term actions which should achieve budgetary savings, we will support reductions in charges in the localities which now have allowed charges significantly above the national average. We want to work with HCFA and PPRC to define the proper surgical bundle for thoracic procedures and end unjustified seperate charges. We will work with HCFA or the Congress to review any data which may be interpreted to show that any thoracic procedures are over-priced under criteria defining inherent reasonableness developed by this Committee and passed by Congress. The legislation developed last year and the procedures now in regulations provide adequate opportunity for review. We would ask, however, that the Congress not take action based on inaccurate or unassessed data that would penalize all thoracic surgeons across the board and throughout the country. If surgical intervention is required, the proper instrument is the scalpel, not a hatchet.

THE SOCIETY OF THORACIC SURGEONS

ROBERT WEBER
Washington Office

June 19, 1986

Henry Desmarais, M.D.
Executive Associate Administrator
Health Care Financing Administration
200 Independence Avenue, S.W., Room 310G
Washington, DC 20201

Dear Dr. Desmarais:

We understand that the Health Care Financing Administration expects to extend its study of trends in reimbursement levels and medical services associated with the provision of pacemakers.

In light of this decision to gather additional information, we would like to renew several suggestions which representatives of the Society of Thoracic Surgeons made originally at a meeting with officials of the Bureau of Quality Control on May 1985:

-- First, we strongly recommend that HCFA include data from a second base period. In 1967 (the base period being used currently), the technology of pacemaker insertion was quite new. As a result, we believe that the data gathered from hospital records and from carriers is likely to be very rough. By 1970, the technology of transvenous insertion was more widely adopted; data from this period will be more consistent and valid.

-- Second, we urge that HCFA gather from hospital records information on whether the pacemaker insertions were performed by a surgeon; by a cardiologist; or by a team composed of both a surgeon and a cardiologist. These factors should be correlated with the type of pacemaker inserted, the type of insertion, and patient outcome. It is particularly critical that measures of patient outcome be included. For example, readmissions for replacement of leads or treatment of complications must be considered in the total cost of the procedure to Medicare. Obviously, the cost of any hospital readmission (even apart from valid questions of quality of patient care) could far offset differences in fees charged or paid by Medicare, in different circumstances, for the original insertion.

-- Third, we urge again that HCFA be careful not to use operating room time as the definitive measure of complexity or of demand on the physician. With the advent of more complex pacemakers and their insertion in patients who would not have been considered candidates for them in 1967 (or in 1970) the demands on the surgeon's judgment and on his time, pre-operative and post-operative, have increased. While this cannot be obtained from operating room records, other measurement techniques, such as proposed in the Resource Based Relative Value Study being undertaken by the Harvard School of Public Health under contract with HCFA, are available.

We appreciate your willingness to review these suggestions. Please let us know if we can provide additional information or assistance.

Sincerely,

John E. Albers

John E. Albers, M.D.
Chairman, Government Relations Committee

JEA/st
cc: Warren Master
Acting Director, Bureau of Quality Control

Bernard Patashnik
Director, Medical Services Reimbursement Division

American College
Cardiology

CHANGING PROFILE OF THE CORONARY BYPASS PATIENT

Keith S. Naunheim, M.D., Gary Roth, R.N., L.R. McBride, M.D., D.G. Pennington, M.D., H.B. Barner, M.D.

Over the last decade the mortality for coronary bypass (CB) has risen at our institution. We compared the records of the first 100 consecutive CB patients in 1975 with those in 1985, and found that the profile of the CB patient has changed significantly. Patients in 1985 are older (61.1 vs. 52.2 yrs., $p < .0005$) and have a higher incidence of congestive heart failure (11 vs. 3, $p < .05$), diabetes (20 vs. 6, $p < .01$), and chronic lung disease (9 vs. 0, $p < .005$). There is also a higher incidence of past myocardial infarction (61 vs. 44, $p < .05$), recent (within 1 month) infarction (20 vs. 3, $p < .005$), urgent or emergency surgery (24 vs. 12, $p < .05$) and history of prior cardiac surgery (7 vs. 0, $p < .01$). In addition, the primary cardiac disease is worse with a higher rate of triple vessel disease (51 vs. 33, $p < .05$), associated mild mitral or aortic disease (10 vs. 0, $p < .01$) and abnormal ventriculograms (70 vs. 57, $p < .05$) as exemplified by a significant increase in LV score (8.7 vs. 7.2, $p < .01$).

Despite more aggressive revascularization (average anastamoses 3.6 vs. 2.2, $p < .001$), there has been a greater incidence of postoperative low output (15 vs. 3, $p < .005$) with a higher incidence of inotropic (42 vs. 9, $p < .005$) or balloon support (14 vs. 2, $p < .005$). Both mortality (8 vs. 1, $p < .05$) and non-arrhythmia morbidity (39 vs. 25, $p < .05$) are higher with increased pulmonary (11 vs. 0, $p < .001$) and permanent neurologic complications (6 vs. 1, $p < .06$).

The CB patient has changed markedly over a decade; with worse cardiac and non-cardiac medical status resulting in a significantly increased morbidity and mortality, despite advances in surgical technology.

APPENDIX I

The PPRC Inherent Reasonableness (IR) Proposal

The AMA has serious reservations with the Commission's inherent reasonableness proposal. It appears that short run budgetary pressures have preempted the appropriate process of deliberation and review for IR application as outlined in OBRA and in the March PPRC report to Congress. The methodology proposed has serious flaws and should not be used to meet arbitrary budget savings.

Comparisons of Relative Values

The initial PPRC analysis focuses on estimated relative values only, and it is based on the relationship between a Medicare RVS and other RVSs relative to a single procedure: cholecystectomy. It fails to examine whether Medicare allowed amounts or prevailing charges are actually higher than the allowed amounts of the payers that use the other RVSs.

Although relative values are important in evaluating payments, the monetary conversion factors that make an RVS into a fee schedule are of equal importance. It makes no sense to lower Medicare payments solely on the basis of implicit relative values without consideration of what Medicare actually pays relative to comparable payers. This is especially important given the combination of MEI constraints and fee freezes that have taken place over the history of the Medicare program, as it is quite likely that in many cases Medicare payments are substantially less than private insurer payments. For example, data from the AMA's Center for Health Policy Research indicate that 1984 usual physician charges for a hernia repair averaged 19% more than the Medicare allowed charges.

A second issue in the comparison of RVSs is the relevance of the relative value scales that are used for the purposes of the comparison. As indicated, there are legitimate concerns with the comparisons under consideration by the Commission:

- Medicare RVS - This RVS is constructed from the weighted average of Medicare allowed charges from four states: Wisconsin, Alabama, Washington, and Connecticut. It is not at all clear that an RVS derived from these four states is an appropriate basis for comparisons that will have national impact. In addition, since the Commission is recommending cuts in prevailing charges, it is not appropriate for the relevant Medicare RVS to be constructed without specific consideration of prevailing charges.

  An examination of the 1984 prevailing charge data shows that the use of allowed amounts from only four states may create a distorted picture of the Medicare relative value as compared to the other RVSs. For example, an RVS constructed from Medicare allowed charges derived from national charge data (provided by HCFA) based on cholecystectomy, produces a relative value for a three artery coronary bypass of 4.55 rather than the 5.71 as derived from the four state analysis. (See Table 1.) Finally, it would be useful if the Commission attempted to quantify the effect of the previously taken reductions on the derived relative values for cataract surgery.

- Insurers RVS #1 and #2/ Group RVS - These RVSs are difficult to evaluate with the information provided. It appears that the two insurer fee schedules are for "indemnity benefits" rather than more comprehensive "service" benefits. Thus, these schedules reflect what the insurers choose to pay given their particular beneficiary populations, claims experience, markets for physicians' services, and premium revenue. In addition, the Group RVS reflects the experience of one group in one major city and has no obvious relevance to Medicare.

  These RVSs are effectively the result of a series of specialty-specific RVSs developed for local markets and may not be applicable to Medicare. Nor are comparisons to cholecystectomy, an operation not performed by all of the relevant specialties, necessarily appropriate. It is probable that the developers of these RVSs have focused on payment levels for individual services and specialties rather than the design of a comprehensive and internally consistent RVS.

Neither the insurers' RVSs nor the Group RVS are based on a Medicare population. This issue may be particularly acute for the Insurer #2 RVS and the Group RVS, which apparently reflect negotiations and deliberations relevant to "preferred provider" plans that do not serve a Medicare market. For such variables as time and complexity, the Medicare population is quite different from the non-Medicare population. This difference is particularly important when comparisons are made with common RVS index procedures, such as cholecystectomy. For example, a cholecystectomy for a 40 year old man may be quite different from a cholecystectomy for a 70 year old man. Such differences are even greater for more complicated procedures, like a coronary artery bypass graft (CABG). These differences will be exaggerated in RVSs that result from local market negotiations specific to particular patient groups. An implicit RVS resulting from this process is likely to have little relevance to Medicare.

- Ontario RVS - The Ontario RVS was derived through negotiations within the Ontario Medical Association. These negotiations and the resultant RVS are obviously the product of conditions specific to Ontario. In particular, as discussed by Mr. Peter Fraser of the Ontario Medical Association in his recent presentation to the PPRC, these negotiations focus on the incomes to be earned by different medical specialties. They do not focus on specific relative values. Here again, the relevance of this RVS to Medicare is unclear.

- Hsiao/Braun RVS - Although the AMA is working closely with Professor Hsiao and Doctor Braun on a current national RVS study, we have serious reservations about the application of their earlier one-state (Massachusetts) study to Medicare. That study was based on data from 110 Massachusetts physicians, and it is limited by methodological problems that the current resource based RVS study has expended substantial efforts to resolve.

The PPRC proposal even notes that Professor Hsiao stated that ~~individual estimates might be subject to~~ some error. The June 1986 report by Mitchell and Stason, used by the PPRC for its four-state Medicare RVS, also states that "before implementing such a reimbursement change, policymakers should consider [that]. . . while our results strongly suggest that Medicare is paying far more for many surgeries than their resource costs would justify, these analyses must be considered preliminary. More work is needed with an RBRVS based on a larger national sample, and the selection of an appropriate index procedure needs to be carefully evaluated." (Emphasis added.)

Finally, it should be noted that the original Hsiao/Braun RVS did not provide a relative value for cataract extraction with a lens implant. Mitchell and Stason imputed a relative value for this procedure from the earlier Hsiao/Braun data on the basis of a discussion with two ophthalmologists.

Taken individually, the five non-Medicare RVSs have little obvious basis for comparison with the Medicare RVS (based on only four states), which is itself not clearly appropriate. Although outlier criteria that use several RVSs represent an admirable attempt to be fair, it is simply not clear that combining inadequate data provides a better basis for selecting Medicare outliers.

Index Procedure

The proposal states that the choice of an index procedure does not affect the results of this comparison. This is simply untrue. If a specific outlier criterion is used, the choice of index matters a great deal. From examinations of the provided data, it appears that a procedure was considered an outlier if the Medicare relative value is greater than the relative values from all of the other RVSs, and greater than 125% of the average for these RVSs. However, our analyses show that with these criteria, use of inguinal hernia repair as the index reduces the number of outlier procedures by more than one half. The importance of the index procedure was also emphasized by Mitchell and Stason. This

point gains in importance when one considers the fact that all of the RVSs, including the Medicare RVS, are highly correlated with each of the other RVSs. The arbitrary selection of cholecystectomy as the index procedure clearly has an important impact on the identification of specific outliers.

In addition, the use of any single index procedure to create RVSs with the same base may introduce variations across the new RVSs that did not exist in the original fee schedules. A recent paper published in the Health Care Financing Review demonstrated that creating RVSs with a common index procedure out of Medicare clinical laboratory fee schedules, which like the PPRC RVSs were highly correlated with each other, actually increased the variation for individual services across the fee schedules. (Paul A. Gurny and Thomas A. Clopton, "Medicare Outpatient Clinical Laboratory Services Payments: Relative Value Scale Approach," Health Care Financing Review, Winter 1986, pp. 45-52.)

As the method used by the Commission focuses on variations across derived RVSs for specific procedures, the imposition of a common index procedure may have distorted and artificially heightened this variation.

Conclusion

The method chosen is marred by unrepresentative and non-comparable RVSs, and is sensitive both to the use of an index procedure and the particular index procedure chosen. Although the Commission has clearly attempted to correct for this uncertainty through what at first appears to be fairly stringent selection criteria and has recommended cuts that are less than might be suggested by the data, the potential errors in both the data and the comparisons make even such attempts at corrections inadequate.

Table 1

Relative Average Medicare Allowable Charges

	CPT-4 Code	Four States (Mitchell/Stason)	National
Coronary bypass, 3 arteries	33512	5.21	4.55
Total hip replacement	27130	2.90	2.87
Femoral fracture	27236	1.57	1.59
Prostatectomy, suprapubic	55821	1.54	1.40
Modified radical vasectomy	19240	1.24	1.22
Lens extraction, intracapsular	66920	1.40	1.15
Cholecystectomy	47600	1.00	1.00
Inguinal hernia repair	49505	0.66	0.64
Cystouretroscopy	52000	0.12	0.11

Mr. COYNE. Thank you, Dr. Albers. Dr. Holtgrewe.

STATEMENT OF H. LOGAN HOLTGREWE, M.D., TREASURER, AMERICAN UROLOGICAL ASSOCIATION

Dr. HOLTGREWE. I am Dr. Logan Holtgrewe, treasurer of and spokesman for the American Urological Association. On behalf of that association, I would like to thank the committee for the opportunity to be here.

We are here to discuss prostate surgery, most specifically the transurethral prostatectomy. Each of us men, as we age, are probably going to be confronted with this problem. It is one of the most common afflictions of the aging male.

The transurethral prostatectomy, or an open prostatectomy, is the only mode of therapy for this condition. The older operation required an incision with opening of the bladder. The new operation, transurethral prostatectomy—not so new, really, it started in the 1930's—does the same procedure through the channel, using an instrument no larger than a standard pen, and through this, the tissue is removed a piece at a time.

If there was ever a cost-effective procedure in the armamentarium of American medicine, it is this operation. Properly performed, at a properly selected time, it prevents incalculable damage to the urinary tract, bleeding, complications, infection and death, the treatment of—all of which—far exceed the cost of the operation itself.

This is an operation which is easily underestimated by the patient, by the referring physicians, even by other surgeons who really do not perform it. It looks like a simple, easy affair. The patient normally, within a matter of an hour or so, is lying comfortably in bed, no problems, feels well, hardly knows anything has happened, but in fact a very delicate internal operation was performed, wherein, if the urologist cuts but an eighth of an inch too deep, a perforation of the capsule can occur with hemorrhage and a variety of very catastrophic complications.

Cutting just a bit too far toward the sphincter can lead to a life of incontinence. We feel that the suggested proposals in cutting of fees, including prostate surgery and prostatectomy, are really not appropriate, and this is why we feel that is the case.

First of all, HCFA has already been charged by Congress with the concept of looking at certain procedures under "inherent reasonableness." Why then should another group look at this same problem from a different direction?

Second, the data upon which these possible cuts are being considered is, we feel, certainly premature, it is preliminary, it is possibly flawed. We feel in the area of urology it definitely is flawed. We feel that while many interesting questions are raised, far more information is necessary.

Third, we wonder if Congress, if it takes this route, is not in fact entering the area of setting fees for given surgical procedures. Does Congress really want to do this? We have heard testimony here today, and questions from the members of the committee, that would certainly indicate this is a most difficult thing to do.

Are you going to set fees on 9 procedures, or 19, or 90, or 900? How many would you select? Now, the last thing is quite unique to urology.

I think the committee should understand, that urology is a small specialty, 1.6 percent of the physicians in the United States.

The transurethral prostatectomy or prostate surgery is the heart of our specialty. This operation is performed almost exclusively on Medicare patients. A cut of this sort would have an enormous economic impact on our field. The urologist practicing would find that his overhead would continue to rise, his malpractice insurance would rise, and yet, here he is, cut off from the major portion of his income.

Thus affected, the older urologist, 55 years of age, or so, would certainly look at his options, and he would say it has become very unattractive to continue to practice medicine. This is the man who is most experienced in this operation because the man who has done 2,000 of these is far better than the man who has done 200. He might very well elect to simply retire, given the economic hardships with which he is confronted, and soaring malpractice premiums

This would have an impact on availability and access to urological care, particularly in communities where there are but one or two urologists. There are many such communities in the United States. The loss of one of these might be placed by a young urologist, but not necessarily so.

The young urologist today would prefer to go into a group practice in suburban or urban America, where he would have the protection of colleagues to help with difficult decisions and difficult cases, and most of all, to pay that enormous malpractice premium with which he is confronted as he begins practice.

As a result, we are very fearful that such an action would end up with a loss of availability of competent, experienced urological care in the smaller communities throughout the United States.

Also, what of the medical student approaching his life in medicine? Would he select a field that has been encumbered by this profound economic disaster?

We realize, of course, that realities exist, and if in fact there must be difficult decisions made as to how budgetary corrections are made under Medicare, we will address this. It is rather difficult to know who is to be thrown from the lifeboat, but given the options, we would feel that we should first look at geographical differences in fees, as has been mentioned earlier by other speakers here today, areas where fees seem to be out of line.

Second, we feel that an across-the-board freeze, where all physicians are handled in an equal manner, really makes a far better and far more logical method of approaching this than to subject certain specialties to horrendous cuts and economic problems.

We feel that the new physician reimbursement could be looked upon as another area of concern. We feel that, however, in the long-run, that really, the across-the-board freeze is the best mode.

We are doing a study at the present time, sponsored by the AUA under the auspices of Multinational Business Services.

In this study we are going to be sending a questionnaire to every urologist in the United States, and we are going to be asking him

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certain pertinent questions, in which we are going to hope to answer questions concerning this particular and very vital procedure.

We feel very strongly, that this information will be productive and will be helpful. We stand ready to work with the Physician Payment Review Commission. We in fact have shown this survey to HCFA, we have shown it to the Office of Management and Budget for their input, and it has been looked at by members from PPRC as well.

We hope that this information will provide us more data. We thank you for the opportunity of testifying today. We feel that the solution to this problem is complicated, but, at present, the best mode is simply for across-the-board freeze, to have minor cuts of an equal nature in all areas. Thank you.

[The statement of Dr. Holtgrewe follows:]

Statement of the American Urological Association,
H. Logan Holtgrewe, M.D., Treasurer

Mr. Chairman and Members of the Subcommittee: My name is Logan Holtgrewe, M.D., and I am a practicing urologist in Annapolis, Maryland. I am also Treasurer of the American Urological Association, and I am pleased to be here today on behalf of the AUA in response to your invitation to examine budget reconciliation issues relating to physician payment under Medicare. AUA's membership of 6380 represents the majority of physicians specializing in urology.

The American Urological Association is very concerned that the nation's budget deficit continues to force the Administration and Congress to seek funding reductions in the Medicare program. We believe that the many program changes and spending cuts that have been made tend to undermine the confidence that patients, physicians, and institutions have in the Medicare system. We realize that Congress is faced with many difficult choices in dealing with the budget deficit. However, we caution you not to choose deficit reduction measures that could jeopardize the future of the Medicare program.

Recognizing the responsibilities you have, AUA believes it is imperative that physicians discuss with you the various deficit reduction proposals affecting Medicare in order to seek those that will cause the least disruption to the delivery of medical services. In the letter of invitation, two issues were raised for consideration. The first is the selective reduction in payment of certain surgical and medical procedures for which current levels of payment appear excessive. The second is an across-the-board adjustment to the Medicare Economic Index. AUA would like to address both of these issues as well as make some additional recommendations to the Committee.

AUA understands that one of the surgical procedures targeted for payment reduction is prostate surgery. We are extremely concerned by this entire approach to budget savings and especially by the inclusion of prostate surgery. We believe there is a fundamental misunderstanding of the procedure. Therefore, before we turn to discussing the specific budget proposals, we think it is important to offer you some insight into prostate surgery, especially the transurethral resection of the prostate (TURP), which is the more commonly performed prostate procedure. It is the volume of procedures performed and the total of the program costs that have drawn the government's attention to this procedure. AUA thinks that an understanding of the procedure is essential before you look at the reasonableness of its reimbursement. Included with our statement is "The Prostate Book", which explains the condition and the procedure in some detail. Urologists commonly use this booklet with their patients.

All men have a prostate gland, and as men age, most of them experience benign growth in that gland. What causes this enlargement is not clearly understood. However, it does occur quite commonly, and the longer a man lives, the more likely he is to experience problems associated with that growth.

Because men live longer today, prostate problems are becoming as common as gray hair and balding. As the prostate enlarges, it spreads, tightens around the urethra like a clamp around a garden hose, and interrupts urine flow. Surgical intervention, a prostatectomy, relieves this problem. There is no medical alternative. However, if treatment is delayed too long, or if the condition is not treated, it can cause bladder damage and kidney failure. Prevention of these conditions is an important aspect of this surgery. Treating kidney failure is far more difficult and expensive than performing prostate surgery. Timely surgical intervention prevents these complications from developing. The TURP is, in the best sense, preventive medicine in that it is curative of the problem and will, if done on a timely basis, avoid complications to the bladder and the kidneys.

Once the process of enlargement begins, the issue is not what to do but when to do it. Remember, for most men who live long enough, the enlargement will cause pain, discomfort, and other problems that can only be relieved by surgery. The question for the surgeon is when is the most appropriate time to perform the surgery. The timing will vary somewhat from patient to patient, but in general, urologists agree that certain indications always require immediate surgical intervention. These include urinary retention, when the blockage has become so severe that the patient can no longer

urinate and will die if surgery is not performed. The second indication dictating surgery would be frequent bleeding or infection. When these sorts of indicators show up, surgery must be performed and quickly. These are the kinds of emergency situations that urologists hope to avoid by performing the TURP early.

The other, more common, indications for surgery are the presence of symptoms of urinary disruption. This generally means that the patient is experiencing discomfort in urination, frequent urination, or other alterations of normal urinary function. The decision to operate depends upon the severity of this disruptive pattern. For some men, it may occur early in the growth of the prostate with obstruction resulting from a relatively small gland; other men may not experience these symptoms until the gland has gotten quite large. The degree of disruption to life caused by these symptoms is very important in determining when surgery will be performed, and each man will differ in his ability to tolerate them.

Thus, we see that the volume of prostate procedures results from an aging male population and the almost inevitable prostatic enlargement that accompanies long life.

The American Urological Association has published standards for various urologic procedures, including prostate surgery, and the indications for performance of these procedures. We think that adherence to these standards and effective utilization review in the hospital are ways to keep the volume at appropriate levels. Congress has already directed the PROs to have mandatory preadmission review and possible second opinions for a number of high-volume procedures. We understand that prostate surgery will be one of the procedures on that list. Thus, utilization review will be broadly applied, and inappropriate procedures should be eliminated. AUA sees this a positive development that can benefit both patient and surgeon.

A distinction should be made between the transurethral resection of the prostate (TURP) and the suprapubic or open prostatectomy. The choice of procedure by the surgeon is based largely on the gland size. A larger gland, perhaps 65 grams or over, is going to be removed by many surgeons using the open procedure. This is a function of the time it takes most surgeons to perform a TURP on a gland of that size. Physician and patient fatigue becomes a very critical factor in those circumstances. For the large gland, the open procedure is much quicker for the surgeon and less fatiguing for all parties. Nonetheless, the open procedure is substantially more expensive in its overall cost because the length of hospital stay for the patient who has had the open procedure is, on the average, twice as long as that of the TURP patient. Both procedures and considered major surgery. The open procedure is also harder on the patient since it requires a major incision which causes substantial discomfort. The TURP does not require an incision, and patients much prefer this procedure. They can be discharged sooner but must be cautious in their activities for several weeks. All of this argues for early intervention so that the TURP can be performed safely, and the patient can then get out of the hospital in three or four days rather than eight or nine.

I believe that you will find most urologists are making an effort to intervene surgically at a time when the TURP can be performed effectively, thus sparing the patient the rigors of open surgery and the cost of a long hospital stay. Given the lower costs overall of the TURP to the government, it would seem that the reimbursement system should be structured to encourage the earliest appropriate intervention on behalf of the patient so that the TURP can be performed.

TURP is clearly the preferable procedure and has been so for many years. First introduced in the 1920s, TURP gained wide acceptance among urologists many years ago. The procedure is largely unchanged since then. Equipment improvements have occurred, most notably in the optics, but there have been no dramatic breakthroughs in technology. The surgical skills needed have remained unchanged. In my personal experience as a surgeon, I find that the only real difference between the procedure I am performing now and the one I performed 25 years ago is that I have now substantially more skill than I did when I first started in practice, which enables me to use the procedure on glands two to three times larger than I did when I first began.

adequate peer review. If it were a new drug, the government would mandate this cautious type of approach. The study of Drs. Mitchell and Stason has yet to be subjected to the kinds of review, comment, and criticism that is appropriate for a work of this magnitude. Until the many questions already raised about this study are answered to the satisfaction of the medical community, the Congress, other researchers, PPRC, and the Administration, Congress should not use this work as a basis to proceed with cuts in payment for selected procedures.

In addition to the overall problems with this study, the authors express a real misunderstanding about urologic surgery. Drs. Mitchell and Stason refer to open prostatectomy as more complex than TURP. This is absolutely wrong. The TURP is much more difficult. Problems like this must be resolved before Congress acts on the basis of their work.

There is no question that there are many issues in physician payment that need to be addressed. For example, are procedures more highly valued than the so called cognitive services? That is difficult to answer, but certainly it is appropriate to look at payment levels and see if parts of the system are really out of whack. One area that we are very concerned about is geographic variation in payments. AUA recognizes that there are legitimate differences in the cost of doing business which need to be reflected in fees. However, we do not think that all the variation in fees can be accounted for on the basis of differences in costs of living. More work needs to be done in this area.

We are also aware that the incidence of procedures tends to vary around the country and we are not at all certain about the rationale for that. However, rather than assuming one answer or another, we would be most interested in working with Congress, HCFA or the Physician Payment Review Commission to see if we can't answer these questions and decide what steps should be taken.

AUA has commissioned two studies to be done relative to TURP so we can get a better handle on what is happening. The first is a major scientific study which will look at the performance of TURP in a variety of settings and deal with the medical issues surrounding it. The second is a survey of all urologists which will look at some of the practice and socioeconomic issues surrounding TURP. We hope that through these two studies, AUA will gain information which will be valuable not only to us but also to policy makers. We would be pleased to share the results of this work with the Members of this Subcommittee when the studies are completed.

AUA recognizes the compelling need to achieve budget savings for FY 1988; however, we hope that Congress will not make a decision today that will cause an erosion in patient access to services some time in the future. We are concerned that older experienced surgeons, at the peak of their career, may decide that the pressures and costs of doing business are too troublesome to continue in practice. These physicians may well decide to retire early, which means that the patient no longer will have available to him the wide range of skill that now exists. For the government, it means that many Medicare patients would have their prostate surgery by the open prostate procedure, requiring many more days of hospital expenses.

We think a clear example of this problem exists in obstetrical care in many states where the incredible growth of professional liability insurance premiums has made the practice of obstetrics either unattractive or impossible. As these obstetricians retire or stop delivering babies, expectant mothers find that their access to care is significantly reduced. In many states, pregnant women now have large distances to travel for their prenatal care. Such a situation is obviously not desirable and we would be disturbed if decisions about payment for Medicare patients lead to similar results. As an example of what happens when cost cutting continues unabated, one only need look at the Medicaid program in many parts of the country. In my own state of Maryland it is often not worth the cost of processing the paper for payment under Medicaid. I see the patient, but I don't process the claim because payment does not cover these costs, much less the cost of the services that are delivered to the patient. It would certainly be unfortunate if Congress took actions that had the same corroding effect on the Medicare program.

Done properly, a TURP looks like a very smooth procedure. In the hands of a skilled urologist, it should be so, since he has had extensive training in it. Educators in urology generally agree that the TURP is a difficult procedure to teach and probably the most difficult urologic procedure to learn. This is because it is a one-on-one procedure in a closed environment. Open procedures such as the open prostatectomy or a cholecystectomy are easier to teach because the physician in training can readily observe and participate in the operation. This is not possible in the TURP, so training is more difficult.

At least one study has compared a TURP to a cholecystectomy in terms of relative difficulty and has determined that the TURP is less difficult. I believe this is incorrect and reflects a lack of understanding of the TURP. I have performed the cholecystectomy as part of my general surgical training, and I still sometimes assist in that surgery. TURP clearly is the more complex procedure. I think one way of comparing the relative complexities is to look at when in the course of physician training a person learns to perform a specific procedure. A general surgical resident will perform a cholecystectomy in the first or second year of training after medical school. In fact, many residents in general surgery could in their second year perform a cholecystectomy competently and with minimal supervision. On the other hand, the urological resident will usually not perform a TURP until well into the fourth or fifth year of training. We regard it as a difficult operation to do and require that the urologist in training have developed substantial skills in many areas before attempting to do it.

Even though the procedure appears relatively simple, it is not. It is major surgery with all of the attendant risks to the patient if not done right. In fact, patients often need to be reminded that they have had major surgery and that recovery takes several weeks. I think the President's experience with his recent prostate surgery is instructive. Despite reports in the news media that the President was undergoing a relatively "simple procedure", his recovery of about six weeks was consistent with what should be expected. That recovery time is consistent with other types of major surgery.

Let me now turn to the particular budget reconciliation items under consideration. One approach being considered involves selective reductions in payment for certain medical or surgical procedures for which current payment levels appear to be excessive. AUA has a number of concerns about this approach.

Last year in the Omnibus Budget Reconciliation Act, Congress directed the Health Care Financing Administration to conduct "inherent reasonableness" analyses of high-volume, high-cost procedures. The purpose was to examine the appropriateness of payments and to make changes as needed. Prostate surgery is on that list. Since that work is still ongoing, we wonder why it is necessary to rush forward on another track and try to undertake a similar kind of effort, but without the study and analysis that HCFA is doing. AUA believes Congress should stick with the procedure developed last year.

The proposal to reduce payments for certain surgical and medical procedures is based largely on a preliminary feasibility study performed by Drs. Mitchell and Stason under contract with HCFA. For the first time, an attempt was made to look at the relative values of certain surgical and diagnostic procedures to see if some of the procedures were overpaid compared to others. Clearly, their work raises some intriguing questions about physician charges and payments. The authors noted the preliminary and tentative nature of their study. We do not view that single study as sufficiently convincing evidence for Congress that would allow intelligent and equitable judgments to be made about the relative worth of physician procedures in general or about the few that they specifically identify. AUA thinks it would be extremely ill-advised to proceed at this time on this course.

We believe the wiser decision would be for the Physician Payment Review Commission to continue to look at this avenue of approach and to make further recommendations after more careful examination and debate. If this were a new medical procedure, physicians would be reluctant to embrace it until there had been an opportunity for replication of the studies and

Two other observations are important. First, the TURP is probably the most common surgical procedure performed by urologists. For many of us, it is the bulk of our surgical practice. A major reduction in payment for TURP would be a severe financial blow.

Second, a cut targeted on TURP payments would punish urologists whose fees have been reasonable far more severely than those few urologists whose charges have been outlandish. Cuts of this magnitude are unfair in the extreme, especially when they are not based on credible evidence that payment levels are improper.

The AUA believes that the time is not right for Congress to proceed with still another version of the "inherent reasonableness" analysis. HCFA is already working on this process at Congress' direction. Additionally, work is ongoing at Harvard on relative value scales and we urge that you wait until that work is in and adequately reviewed before you make any decision to fundamentally alter payment levels or mechanisms. We certainly have concerns about the way that program at Harvard will come out, but we think it is preferable to work within that framework rather than to simply make arbitrary decisions about payments for selected procedures.

Mr. Chairman, AUA recognizes that program savings must be found in order to meet the budget targets. We have a specific suggestion for how the Congress may be able to provide savings without significant program disruption. AUA believes that some savings can be found from adjustment to the Medicare Economic Index. We are not enthusiastic about another freeze and we recognize that other medical organizations do not share our view. However, we believe that it spreads the misery and does not unduly burden any one specialty or any one procedure. You may wish to recommend that certain physicians who would be especially disadvantaged by a further freeze get some special consideration. In any event, we feel that adjustments to the Medicare Economic Index are an appropriate source of savings. Further savings could come from holding both customary charges and prevailing charges at current levels. We urge that the Congressional Budget Office be asked to estimate the savings from these actions.

AUA has also looked at the recommendation in the President's budget to modify the ways in which new physicians are paid. We believe that there may be some merit to this proposal simply because the current system is so restrictive on the existing practitioner but is relatively generous to new physicians. Some balance should be restored and we would urge a careful examination of this proposal. Adoption of this idea is not without its peril, however. We would be concerned, for example, if changing the payment methodology for new physicians, especially in those parts of the country where medical payments are traditionally low, would affect decisions on where to locate. One of the advantages of an increased supply of physicians is that many of them have moved into parts of the country where physicians numbers are traditionally low. We would not want this particular payment change to inhibit that trend. The proposal should also be examined for its impact on physicians already in practice. Would it lower their payment because of its impact on the prevailing? This needs to be examined carefully.

As noted earlier, we are also concerned about the geographic variations in payment. We think that this is an area which the Committee could look at and perhaps find some initial savings this year and other savings in future years as the methodology for reviewing these problems becomes more secure.

Mr. Chairman, our preparation for this hearing has raised for us many questions and difficult issues. We were struck by the fact that there does not seem to be an especially good arena for dealing with all of these issues. Where do physicians, insurance companies, government payors, and beneficiaries go to try to resolve these complex problems? The AUA believes that the Physician Payment Review Commission (PPRC) offers a framework that can be used. We would urge Congress to strengthen and enhance the role of the Commission in order that it may serve as a catalyst for bringing parties together to resolve these issues. We think then the Congress would be able to get recommendations that reflect as much consensus as is achievable. We would be pleased to meet with the Members of this Subcommittee to discuss this idea in more detail.

Mr. Chairman, in conclusion let me say the following. First, the American Urological Association is deeply concerned that the Medicare program continues to be a target for budget deficit reduction. We are very concerned about the future of the accessibility and quality of services for patients under the program. Second, we are persuaded that the proposal to cut selected procedures should not be adopted at this time. Much more work is needed. Third, we believe that short-term budget savings under Medicare can be found in proposals to adjust the Medicare Economic Index to hold customary and prevailing charge levels constant and also in adjustments in the way new physician payments are determined. Fourth, geographic variations is a problem which is deserving of your attention and which may offer some savings to the Committee. Finally, Mr. Chairman, we would urge that PPRC be given a stronger mandate from the Congress to provide a forum wherein many issues regarding physician payment can be worked through.

This concludes our statement. I would be pleased to respond to any questions that you or the Members of the Subcommittee may have.

(An attachment to the statement is retained in committee files.)

Mr. COYNE. I would like to thank all of the panelists for their testimony, and I would like to ask Dr. Stokes, and Dr. Dodick, on average, how long does it take to perform a cataract operation?

Dr. STOKES. I was at a meeting this morning where this was being discussed in preparation for some testimony tomorrow at a HCFA meeting, and the conclusion was—and this is to eliminate perhaps some misinformation. The operation, from the time the surgeon injects behind the eye, to deaden the eye for the operation, which is technically the beginning of the operation, until the patch is put on, is somewhere between an hour and 15 minutes, an hour and a half.

The surgical time itself is probably in the range of an hour, on the average. It is unfortunate—and I have a copy of an article that was in a major publication yesterday—that there are those ophthalmologists who do a volume procedure, a volume operation, and who claim that they do 10 and 15 minute cataract operations.

Indeed, there are those few very visible people who make that statement. We know that is not physically possible, to do the entire operation, No. 1, and, No. 2, we do not think that serves any useful purpose because it is totally inaccurate.

Dr. DODICK. I would in essence concur with everything that Dr. Stokes has said, but would point out to this committee, respectfully, of course, that in addition to that absolute surgical time in the operating room, there is an inordinate amount of time spent with the patient, globally, before the surgery, explaining to them the concept of the surgery, and the risk/reward, and all the care associated with the surgery, and the postoperative care, which is bundled in that global fee.

I do want to take this opportunity to point out, too, that in one of the statements quoted today, on which implant reimbursement fees were calibrated, and that based upon the time necessary to do a cataract without an implant versus the time taken to do a cataract operation with an implant, were only minutes apart.

I really think that is flawed, and that may hold true 10 or 20 years ago. But you see, the way I look at it today, it actually takes longer to do a cataract without an implant than it does with an implant, because over 96 percent of all cataract surgeries today include an implant, and when the surgeon does not put in an implant, there usually has been a problem that has occurred in the operating room, necessitating him to clarify that problem, and ultimately lengthen the procedure, and ultimately end up by not putting in an implant.

So I just wanted to clarify that piece of testimony entered in evidence today concerning a great deal of weight placed on the time doing an implant versus not doing an implant.

Mr. COYNE. Either one of you can respond. How much does Medicare reimburse for a cataract operation?

Dr. STOKES. The average last year across the country was approximately $1,600.

Mr. COYNE. $1,600?

Dr. STOKES. $1,600. With the 10-percent cut this year, the rate dropped to an average of $1,450 across the country.

Mr. COYNE. Is it correct to assume that a busy physician could perform several cataract operations a day?

Dr. STOKES. The average, across the country, is that an ophthalmologist does two a week, but there are those practices where there is a volume of surgery, and certainly, there are surgeons who do four, five, or six in a day, if they have a day of surgery.

Most ophthalmologists have a day in which they do their surgery, and, if they have a large-volume practice, may do more than a couple.

Mr. COYNE. Did you say that the average is two per week?

Dr. STOKES. That is my understanding, across the board, of those ophthalmologists who do cataract surgery.

Dr. DODICK. That is correct.

Mr. COYNE. I guess the question is why should Medicare pay $1,500 per procedure when the average amount that a physician is reimbursed for an office visit is $30 per visit. Could you give an explanation for something like that?

Dr. STOKES. Well, while I am certainly not prepared to embrace the Hsiao study, I think that many of us here on this panel are alluding to the desire that there be some delay in specific cuts until we get more of an appreciation of the real picture with all of the data that can be gathered.

There are procedures within ophthalmology now—and I certainly will not pick on another specialty—there are procedures within ophthalmology, where the risk to the patient is perhaps greater, in terms of requiring general anesthesia, where the time of the operation is greater and yet where the reimbursement is perhaps half of what it is for cataract surgery.

So there are those unique defects within the reimbursement system which have evolved over the years, and the point that we would make today—and Dr. Dodick certainly has offered some alternative to cutting the surgeon's fee—the attitude of the implant society, the concern that we have as an academy, representing almost all of ophthalmology, is that we have, with the cuts for the surgical fee itself, as well as other cuts related to the operation—there have been some major cuts—which means that Medicare is paying a lot less dollars.

The one statistic that I think would be very supportive of an across-the-board index reduction, or freeze, as opposed to a further reduction in cataract surgery, and even HCFA agreed to this last year. Beginning with data in 1978, and extending up through the available data for last year, the increasing cost of reimbursement to a surgeon for cataract surgery, above the cost of increases for other health-care delivery, was completely eliminated with this year's cut.

In other words, there was a discrepancy between the amount that surgeons were paid for a cataract operation with an implant versus all the other increases in cost of health delivery from 1978 on.

It was for that reason, among others, that the American Academy of Ophthalmology offered an alternative to the HCFA proposal last year, which embraced, actually, more than the 10-percent cut which Congress finally decided upon for cataract cuts.

But with the cut last year, and even before next year's cut, the surgical fees for a cataract operation now, beginning back in 1978, are in line with all the other increases for health care.

So, we feel very strongly that we took out cuts, and we are also back fully in line with the other procedures.

Dr. DODICK. Congressman Coyne, in direct response to your question, I would only add to Dr. Hunter Stokes' testimony, that testimony offered in evidence by my urology colleague today, that as Dr. Stokes and I have both pointed out, cataract surgery, on the average is done two a week by the average ophthalmologist, 14,000 in number throughout this country, and it is the mainstay of surgical and/or other income that if it were dramatically reduced, would impose upon us the same fundamental problems that were so clearly articulated by my urologic colleague. In addition to that fundamental fact, cataract surgery is, as Dr. Stokes and I both pointed out, a very complex procedure. Hardly in any other procedure can I point out one in which there is so much patient risk. Many patients regard the risk of blindness as greater than the risk of death. Very rarely is there another procedure in which a patient benefits so much. I have often heard patients describe themselves as literally and functionally being reborn again after successful cataract surgery. And this has all come about because of the dramatic technological advances that have been made in our field. It is a procedure that is technically sophisticated, requires constant updating. Many of the cataract surgeons are constantly attending, on an average of five meetings per year, to upgrade the continuing evolutionary changes in the technical nature of this procedure that almost change, in some detail, annually. So in addition to all else that is being said today, it is quite a complex procedure and I would like to add these fundamental issues in direct response to your question.

Mr. COYNE. Thank you very much. Mr. Gradison?

Mr. GRADISON. Thank you very much, Mr. Chairman. Mr. Chairman, I would like to welcome and thank all of the members of the panel but a special welcome and thanks to John Albers from our community, a leading member of the profession, active in the academy. It is hard to conceive of medicine in Cincinnati without his active hand playing a part, and I am delighted to see him here. Mr. Chairman, I have a question I would really like each of the panelists briefly to address. I think it may lend itself to a brief response. How does the level of reimbursement you receive from Medicare compare with the level of reimbursement you receive from other payers in your own individual practices for the procedure we have been discussing, cataract surgery with inocular lens implant?

Dr. DAVIES. Well, I am a general internist——

Mr. GRADISON. Well, so with your work, then. Let us take your specialty then, let us do it that way then.

Dr. DAVIES. My basic procedure is office visits. I sit down and talk to people most of the day.

Mr. GRADISON. Right

Dr. DAVIES. And for Medicare, I am paid $28 for half an hour office visit, $28. For non-Medicare, I charge $35. And to put this in perspective, I was on call this weekend from Saturday morning until this morning when I got on the airplane, saw six people in the hospital twice, admitted three people, one with a heart attack, one with pneumonia, one who had gastroenteritis. I was up most of

Saturday night, and I think my billing for these people would equal one-half of what a cataract operation would be charged for.

Mr. GRADISON. But basically you would be getting $28 a half hour versus $35 in private?

Dr. DAVIES. Right.

Mr. GRADISON. Dr. Graham?

Dr. GRAHAM. I think it is fair to say that the experience of our members is very similar to that which is described by Dr. Davies. As a matter of fact, because there are still specialty fee differentials, you will find family physicians carrying out very much the same functions that he has described to you, with even a lower prevailing or UCR level. Without a doubt, the reimbursement available to family physicians through the Medicare program, is far below reimbursement available through private indemnity insurers, or the amounts made available through the manage care systems.

Mr. GRADISON. Dr. Stokes, how does the Medicare reimbursement numbers that you cited compare with non-Medicare payment for the same service?

Dr. STOKES. I am in a group that participates in Medicare. Our private insurers pay us basically the same amount. We find that as soon as Medicare alters a fee schedule, that the private insurers respond in kind so we find that there is very little differential between—to my knowledge, there is really no difference between what Medicare pays and what the private sector pays or between what Medicare pays and what we charge the patients. But we are participating physicians and that might make a difference.

Mr. GRADISON. Dr. Albers?

Dr. ALBERS. In our reimbursement for Medicare versus that from private carriers, of course, there is a differential in private carriers and there are so many different types of insurance that the person is carrying. But on the average, it will vary between 25 and up to 35 percent being that much lower than what we get from private carriers.

Mr. GRADISON. Thank you.

Dr. HOLTGREWE. In urology, the prostate operation we were discussing, the reimbursement under Medicare is below that of the standard Blue Shield patient in the State of Maryland, where I practice, by a considerable amount.

Mr. GRADISON. Dr. Cooper?

Dr. COOPER. We run about 20 percent less.

Mr. GRADISON. And Dr. Dodick?

Dr. DODICK. Congressman Gradison, I find myself in the unique position coming from New York City from the silk glove area and where expenses have mounted to an astronomical height. I employ a staff of nine people and as sole practitioner, my costs have risen dramatically over the years. It is not uncommon for rental to be $65 to $70 a square foot. I have 1,200 square feet. My rental alone is the equivalent of $80,000 a year. But more succinctly and fundamentally answering your question, I am now reimbursed at about 32 percent less for a Medicare patient on all services issued than on a standard patient. And if my practice, as of this year alone, were to be transformed into the treatment of an over-65 beneficiary on an assignment basis, I would be hard pressed alone, even with

my cataract volume, to cover the costs of my nine employees, my astronomical rent, and my ever-mounting costs, given the specific locale where I practice. But in direct answer to your question, approximately 32 percent than in the private sector.

Mr. GRADISON. Thank you. Thank you, Mr. Chairman.

Mr. COYNE. Mr. Levin?

Mr. LEVIN. Thank you. Dr. Davies, in your testimony you said, on page 4, clearly Medicare payments for some medical and surgical procedures are artificially high while payments for others are ridiculously low. We have the privilege and the responsibility and maybe the pain of taking generous statements and applying them so, unless we do it across the board, I suppose that is one way we do not have to be specific. So, if I might, let me ask you, based on your experience and your expertise to be specific.

Dr. DAVIES. Well, I think you heard some of the high procedures that are being done and I think they are exceedingly high, too.

Mr. LEVIN. Which ones?

Dr. DAVIES. Well, I think the cataract surgery. I had not thought of prostatectomy before, bypass surgery. I think these are excessive.

Mr. LEVIN. Tell us why.

Dr. DAVIES. You have to look at the net income of physicians. At some level, it becomes obscene. Now I do not know what the level is, it may be $300,000, it may be $600,000, it may be $150,000. I do not know that. But it is certainly at some level. physicians' incomes become obscene. Does that make sense? I mean, that is the way I feel about it.

Mr. LEVIN. Well, but is that the basis for your statement—that the Medicare payments are artificially high because the typical ophthalmologist who undertakes cataract surgery performs two a week? What is the basis for saying that the reimbursement for cataract surgery is artificially high? Is it the overall income of the cataract surgeon or other reasons?

Dr. DAVIES. Yeah, that is certainly part of it and the other reason, as I stated. It seems when I am tired Monday morning from having worked all weekend and made $600 or $700, that making $1,500 at one 30-minute, 45-minute, hour procedure, it seems to be excessive. But there is no other way to put it. I wrote a letter to a nice lady that I met in Washington, Judith Jones,—do you know Ms. Jones, head of the National Health Policy Forum? And if I may read just one short paragraph, it says:

> * * * a few physicians are surely working the system solely for monetary gain—I suspect that most of those whom we feel are grossly over-paid, are simply overestimating their value to society, and the third party payers have gone along with them. It seems to me to be a rather simple task for Congress, the final arbiter, to say "hold on there, doctor, you have over-valued your services. This is what the majority of Americans think these services are worth at this particular time."

Mr. LEVIN. How about bypass surgery? What is the basis for your concluding that the reimbursement is artificially high?

Dr. DAVIES. Well, the total incomes of most bypass surgeons in my area and the amount of work that they have to do I must tell you, it is not limited just to surgeons. There are subspecialty interns who, I think, do the same thing.

Mr. LEVIN. Yes.

Dr. DAVIES. Gastroenterologists some of them, cardiologists some of them. It is not just surgeons.

Mr. LEVIN. So it is based on primarily on the overall income of the physician or the difficulty of the procedure in bypass surgery?

Dr. DAVIES. It is overall income, the difficulty of the procedure, the length of time it takes, the skill it takes to do it, the risk involved, to an extent the value that the patient gets from the procedure. Many factors.

Mr. LEVIN. Well, OK. Would anybody like to respond to that? I assume at least two people do. Yes, Dr. Albers?

Dr. ALBERS. There are inequities in payment services. I think all physicians recognize this. There are physicians that do things that probably are not reimbursed as well as they can be and there probably are some physicians who are overreimbursed. I think everyone will recognize that. But to make blanket statements, to say that physicians or one group of physicians are overpaid for what they do, I think is very irresponsible without understanding what other physicians really do and I do not care to get into a permanent discussion or argument with one of my colleagues. I come from an area where I think that fees are reasonable by most of the physicians in that community and when I say about most of the physicians, I am talking about 90 percent of the physicians in that area. If I talk to somebody from maybe certain other States, they may say well, there are inequities in our area but to state that a person is overcharging for a procedure that has a high degree of risk to it, a high degree of stress to it, that is very complex, that takes a lot of time preoperatively, and postoperatively—in our area, the cardiac surgeons do all of the postoperative care—plus the followup care in the office and then the patient receives a tremendous benefit from this procedure. In some, it will be very lengthy and in other ones it may be short, but it is a benefit and to state that the fee for that procedure is overvalued, I think is irresponsible.

Mr. LEVIN. Let me ask you briefly, and then I guess we will try to wind this up. What do you make of the table in Dr. Lee's testimony which indicates that in least for four States, on a relative value scale, Medicare reimbursement is considerably higher in each case, than reimbrusement by other payers?

Dr. ALBERS. Well, without having more data in front of me, it is difficult to make a judgment but the States that they mention that they used, to me, seems to be States that have either not used relative values for a long time or that are using a method that is different from what the Medicare method of relative value scale may be. Why did they not include California as a relative value scale State? California has had relative values longer than anybody else. In fact, relative value scales from California have been utilized by several other States. Secondly, Florida has a relative value scale which is very adequate. Now, I cannot come up and give you a definite answer because I do not know where they got their data and how they collected it. I do not know what their base value is that they are using. But I know, in our particular area, if we were to use this same difference, I think we would find that the relative value scale of Medicare was less than that of the insurance companies as to what they are paying.

Mr. LEVIN. All right, we were just discussing here the California experience. Dr. Albers, if the evidence from, let us say, 15 other States came out about the same as the four States, what would you say then?

Dr. ALBERS. I think I would have to say from what area, from what years did they do this? Is it including the last 5 years relative value scales, or they have been made up a long time ago?

Mr. LEVIN. Well, say it was.

Dr. ALBERS. Say it was? Well, we have got a lot of hypothetical things going on here. If the relative value scales of California and Florida, those that have been in use for awhile which have been time-tested, would come up with this same thing, I still would question the results because I do not believe that this is really what the data will support. Now, I do not know how they collected their data, I will say that again, but it is extremely concerning to me that they came up with such a high figure of relative value scale for coronary artery bypass surgery for instance, as compared to the two insurance companies when, at the same time, they say they cannot get the data on what they are paying for coronary artery bypass surgery on a national level.

Mr. LEVIN. All right. Just one last question for a minute, Mr. Chairman. Those of you who have suggested trying to iron out geographical imbalances, do any of you have any idea how much that would save?

Dr. GRAHAM. Well, Mr. Levin, without committing oneself to a specific methodology, the savings would be pegged to your index. If you were to go down the row that I have suggested or other on the panel, and there were some differences between those suggestions, and essentially that you would try to bring under control some of the geographic variation that exists and some of the specialty variation that exists, I believe it would be up to the committee or to the Physician Payment Review Commission, or HCFA to determine what the target savings would be because that simply depends upon what value you put on a derived figure or a derived ratio. I think the thrust of the arguments that I hear being suggested to you is that even within our differences among ourselves about the relative value of a given service or set of services, that you do hear a panel of professional before you all saying within a given service there may be unacceptable variations of payment geographically, and we think that is something that is worth the committee's time to examine.

Mr. LEVIN. Except it is so general and there is no idea of how we would apply it and what it would save. Within a few months, we have to come up with a specific proposal and I think, just listening to yourselves, you can see why there has been some appeal in the past in across-the-board approaches. We do not have the luxury of being general unless we are across-the-board. We have to know fairly precisely what will be the bottom line result of anything we adopt. Well, I think this has been highly useful to underline the difficulties as well as the differences.

Dr. STOKES. Mr. Levin, in response to your question, I do not have an absolute dollar figure but I would—I have some concerns. Last year, the American Academy of Ophthalmologists' counterproposal to HCFA in terms of cuts for cataracts, did embrace a so-

called sliding scale to identify those States where the fees were significantly higher than the average. We actually recommended that for a couple of States that were more than $1,000 above the average, that their fees be cut by a total of 18 percent.

Now, in the congressional wisdom at the time of reconciliation, that was not adopted as a part of the cut, primarily because there was not enough information available to appreciate it, as I understand it, the impact of that. We asked HCFA that last year. I think, and this is my opinion and perhaps it is inappropriate to express, but almost everyone on this panel has expressed some concern because we represent constituencies that have some concern that some of the impression about the very high rollers, the very high rates that are visible and are public, are not the norm and that there are some variations, either within a region or for certain regions, and there should be someone addressing that. And it seems to me that, as the thoracic surgery spokesman stated, HCFA seems to come up with all the data they need to support the proposals they make. But when there are other proposals that perhaps would address the issues equally well, then somehow this information is not always available. I think that we representing the specialties, might be able to gather that data in an objective and fairly accurate fashion but I have a feeling, representing ophthalmologists who do cataract surgery, that unless the entire budget deficit is resolved with your actions of this subcommittee today, that we may well be back talking to you again next year. And I can assure you that if we survive as a specialty and I can assure you that at that time, we will still be concerned about these variations and so I would hope that perhaps there might be some direction—some effort made to ask HCFA to gather that data so that you would have it available because I am sure that there are millions of dollars to be saved for cataract surgery. I just do not know how many. But I think the answer may be the same next year again if we do not try to gather it.

Mr. LEVIN. Of course, Dr. Lee did not testify on behalf of HCFA, right?

Dr. STOKES. No, sir.

Mr. LEVIN. All right. One last quick question. Would the association oppose a limit on the number of Medicare reimbursements a year?

Dr. STOKES. Would the academy be opposed to the number of procedures that an ophthalmologist would do under Medicare and then be reimbursed for?

Mr. LEVIN. Right.

Dr. STOKES. I think we would, yes, sir. I think that would be counter to the free enterprise system. As I have expressed, we have some concern about some of the things that have happened with some very high volume surgeons but I think that there would be areas that could easily become underserved if there was a limit to how much work a physician could provide under Medicare and be reimbursed for.

Mr. LEVIN. Thank you. Thank you very much.

Chairman STARK. I apologize to the panel. I was called away on an issue dealing with the prescription drug benefit under our catastrophic bill which had to get resolved this afternoon. Of course, it

is not resolved. But I am sure that all the questions were asked. If there are any of you who have any final statement that you would like to make before we adjourn, I would entertain that at this point. Otherwise, thank you all for your patience, indulgence, and your help and I appreciate you taking the time to be here. The meeting is adjourned.

[Whereupon, at 4:40 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

TESTIMONY OF
EDWIN M. COHN, M.D., FACG
NATIONAL AFFAIRS CHAIRMAN
OF
THE AMERICAN COLLEGE OF GASTROENTEROLOGY

Mr. Chairman and Members of the Ways and Means Committee, I am Dr. Edwin Cohn, a practicing gastroenterologist, and Chairman of the National Affairs Committee of the American College of Gastroenterology (ACG). ACG represents approximately 2,200 specialists throughout the country.

Of primary importance to our organization is providing the best care available to our patients. A great percentage of our patients are elderly individuals who are beneficiaries of the Medicare program.

The most significant point I wish to make is that we in health care, and health policy should constantly remind ourselves that beneficiaries of the Medicare program deserve to be extended every health care opportunity that is available to insure their good health and longevity. So, as we deliberate options for budget reconciliation through savings in the Medicare program, it is vital to remember that this is not just a numbers game. Medicare policy translates into health care policy. Significant cost cutting in the Medicare program has every reason to translate into reduced quality of care for Medicare beneficiaries. There is no justification anywhere to permit Medicare to become a second class benefit to our nations aged population. ACG certainly does not think of elderly Americans as second class citizens.

The American College of Gastroenterology does not endorse any cuts in the Medicare program. In recent years, Congress and the Health Care Financing Administration have made significant reductions already through changes in policy and trimming of payments. Yet we recognize the inevitability of budget reconciliation will yield some recommendations from Congress in the form of Medicare cuts.

The Physician Payment Review Commission outlined several options for our comments. During a hearing in May, the American College of Gastroenterology responded to these options. The second option proposes an "inherent reasonableness" plan that would establish a uniform percentage reduction for a number of procedures regarded as outliers. Diagnostic colonoscopy is listed as one of the outliers. ACG questions the criteria used to determine diagnostic colonoscopy as an outlier, subject to reduction in payment. As well we find it difficult to find the common denominator that singles out a number of the procedures listed, unless volume of procedures is a consideration.

Diagnostic colonoscopy is utilized by specialists as a tool for detection of serious gastrointestinal disease and for many precursors to serious digestive aliments. Technology in recent years has improved this procedure to a point where an endoscopic specialist can more readily observe signs of disease at an early stage, or detect percursor signals such as polyps in the colon. Because of this advanced technology, as well, the need to perform more costly exploratory surgery is diminished significantly, thus producing a net savings to the Medicare program. Utilization of this enhanced diagnostic and therapeutic capability has increased recently, but at a demonstratable savings, and as an improved health care resource for our elderly patients. The best method of dealing with gastrointestinal disease is through early screening and detection.

So, while utilization of this procedure may be up, the American College of Gastroenterology believes a major component of this increase is attributable to improved patient care. Peer review mechanisms are in place throughout the Medicare system to prevent over-utilization of a procedure, or inappropriate use of a procedure. Specialty societies in endoscopy have developed standards for the appropriate use of endoscopy, and when followed, insure that unnecessary procedures do not occur. Singling out diagnostic colonoscopy arbitrarily because

utilization has increased does not make sense. Further, assigning it as an "outlier" is confusing because it does not appear that there is sufficient data to support this catch all term. The Health Care Financing Administration is currently conducting an inherent reasonableness analysis under a specific charge from Congress (and apparently has preliminarily stated that colonoscopy was not over-reimbursed). It would seem inconsistent for Congress to suggest a drop in payment while HCFA is still studying the question. We respectfully request that you reject this option and save judgement on specific procedures until more is known to substantiate these unjust, arbitrary outlier designations.

If in fact it is necessary to recommend cuts, the ACG urges Congress to deal with costs savings through improvement in various administrative items. For example, Medicare and insurance fraud are estimated at $1 million per day. A significant savings could be achieved through elimination of these revenue draining fraud cases.

Certainly while Congress, PhysPRC and HCFA is gathering information and data to best recommend physician pay reform, the least prudent choice would be to single out specific procedures and make a blanket cut. The American College of Gastroenterology does not endorse the idea of an adjustment in the Medicare Economic Index, or an overall percentage freeze in fees for service. Nor does ACG endorse proposals that would reduce payments for new physicians. However, given the current budget stituation, these may be the least painful approaches to a short-term savings while PhysPRC and HCFA consider well-thought out, viable options.

The American College of Gastroenterology recognizes the tough choices that face you in the coming months. If, in any way we can assist you in carrying out your mission, we offer our expertise.

Thank you for the opportunity to present our views.

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ECONOMIC POINTS TO BE CONSIDERED IN REGARDS TO AMERICAN HEALTH FINANCE AND INSURANCE, PARTICULARLY THE MEDICARE AND MEDICAID PROGRAMS.

> "Today we spend apprximately $1892/year for health care for every man, woman, and child. We spend two to three times on average that for the retired. A child born in 1985 can expect, at a minimum, a total health bill of $134,000 in his/her lifetime. Since 1965 in avoiding National Health Insurance we have had a doubling of of 'real' national health expenditures. At what point are you going to 'throw in the towel' and get out of health care provision?"
>
> Questioner from Audience to Business Panel,
> Secretary's Conference on Retiree Health
> June 26, 1987

In 1965, after twenty years of debate, Medicare Parts A & B (dealing with health insurance for the disabled and over 65) and Medicaid (dealing with health insurance for the impoverished) was established for the nation at the same time. A review of U. S. health expenditures since that time with comparisons to other nations' health expenditures should be reviewed. Average yearly health expenditure growth for the U. S. since 1960 has been .22% of U. S. Gross National Produce (GNP) annually or 2.2% per decade. In the developed world (OECD) the growth has been .14% of their average weighted GNP annually, or 1.4% per decade. U. S. growth has been approximately 157% of the average for the other developed nations of the world. In addition to growing faster, U.S. health outlay was higher to begin with, being 129% of the OECD average at the beginning of the baseline comparison, 1960. Experts agree that U.S. health care has grown more rapidly and from a higher base than any other developed economy in the world. At present the expenditure is approximately $456 billion (1985), or something like $1692 per year for every man woman and child in the nation. What has accounted for this economic event?

The table below gives some indication.

SELECTED INTERNATIONAL COMPARISONS: HEALTH EXPENDITURES/GROSS NATIONAL PRODUCT

	U. S.	OECD	CANADA	U. K.
1960	5.3%	4.1%	5.5%	3.9%
1965	6.1%	4.7%	6.1%	4.2%
1970	7.6%	5.6%	7.2%	4.5%
1975	8.6%	6.7%	7.4%	5.5%
1980	9.5%	6.7%	7.4%	5.5%
1985	10.9%	7.6%	8.6%	6.2%
RATIOS				
1985/1960	104%	85.3%	56.4%	36.2%
1985/1965	77%	62%	41%	48%

(OECD represents GNP weighted average of 21 developed economies)

FOUR ESTIMATES OF U. S. HEALTH EXPENDITURES
THRU 2035 (percent GNP)

	MIN	HISTORIC MAX		AVERAGE (MIN-MAX-HIST)
1995	11.9	13.0	13.2	12.7
2005	13.0	15.2	15.5	14.6
2015	14.1	17.4	20.0	17.2
2025	15.2	19.6	24.7	19.8
2035	16.3	21.8	30.4	22.8
Delta (GNP)	11/dec	2.2/dec	3.9/dec	2.4/dec

The question presented the American health economist and legislator is: What is the expectation for health expenditure growth in the U. S. economy for the next several decades under different legislative and economic scenarios? Arithmetically it could be concluded from trend line analysis that, absent any major policy change, the growth of health care expenditures as a percentage of GNP would be 2.2% per decade. In other words, the period 1985 - 1995 would go from 10.8% GNP to 13.0% GNP; THE period 1995 - 2005 would go from 13.0% GNP to 15.2% and so on .

MINIMAL INCREASE POSSLBE/LIKELY

I would like to address the concept of the minimal increase that can be actuarilly forecast for health expenditures, assuming the present pluralistic health care system continues in form and style substantially as it exists today. At least five major health factors exist today to raise the proportion of national product spent on health care; there is one major unknow to be considered, and there are three economic/ social factors that will drive government policy and limit governmental options in all areas of expenditure . Factors that must be considered individually are: (1) an increased supply of physicians graduating from medical schools, raising the total number of practitioners to a projected 630,000 in 2035; (2) the ageing of the population, independent of the increase in the numbers of aged; (3) an increased number of aged beginning in 2011 due to the birth of 74 million "baby boomers" between 1946 and 1965; (4) technological improvements in the diagnosis, management and administration of health care and services to include the increase and diffusion of all levels of technology; and (5) the normal growth of population due to immigration, births in excess of deaths, etc.

An unknown factor of significant proportions in 1987 is the appearance of the Acquired Immunodeficiency Syndrome (AIDS) which is currently expected to affect 1.5 million Americans by 1991 and cost approximately $75,000- 100,000 per case/year according to the recent Institute of Medicine Report.

Three economic factors that limit local, state and national government options is the large unfunded pension liability particularly before state and local employees, and Federal Civil Servants and retired military. Although previously addressed, social security funds are by no means certain for the retirees of the year 2011 and beyond. Second, because of large & continuing trade deficits it appears that the U. S. will have a substantial foreign debt to service throughout the early 1990's and beyond. Finally, debt service on the $2.5 - 4.0 trillion national debt will continue to be a constraint on other governmental functions depending somewhat on interest rates and the societal propensities to save and to be taxed. Not included in this

assessment are such factors as the increased participation and specialization of other health professionals; unexpected breakthroughs in the management or treatment of disease groups; or the possibility of a major war and its consequences.

PHYSICIAN SUPPLY: PROJECTIONS

The first of these factors is the supply of physicians. In Canada, sixteen (16) medical schools have an enrollment of 7350 with approximately 1837 students being graduated annually. In the U. S. 127 medical schools have 66,604 students with 16,661 students graduating annually. This is approximately an 89% increase over twenty years in Canada, and a 102% increase in the U. S. Each medical school has larger classes graduating and there are forty plus new schools since 1965. It is possible to imagine a small future decrease in class size at the 143 school in the U. S. and Canada, and perhaps a handful of marginal schools might close because of location or absence of funds for renovation and rehabilitation of physical plant. However, students of public policy, human nature and academic medicine would be skeptical about any wholesale reduction in programs or in any resulting decrease in number of medical school graduates. Put another way, the class of 1945 is retiring from the active practice shortly, and they are being replaced by the class of 1986. Since the class of 1986 is substantially larger than the class of 1946, what will be the economic impact of their entry over the next forty to fifty years? When this question is addressed, the cumulative impact of the classes entering since 1986 and those classes expected to enter after 1986 should be analyzed for economic impact by economists, actuaries and statisticians.

The organized medical profession today consists of 460,000 active practitioners in more than 200,000 predominantly small entities, each generally behaving as a small business. There are 128,000 primary care practitioners, alone. This group of individuals and small businesses are represented very effectively by one of the strongest trade group/professional unions known on the American political scene, the American Medical Association (AMA) and its state, county and affiliated bodies. The market has exerted only minimal force on the organization and remuneration of physicians; this is not expected to change significantly. Physicians are substantially able to generate and control their own demand.

It is my rough calculation that the increase of active physicians from 460,000 in 1985 to 635,000 in 2035 will result in a yearly increase of one billion dollars in health expenditures for each two thousand physicians added to the system. This is an increase that is linear and begins at $1.75 billion in 1985 and ends at $86 billion in 2035. The cumulative addition would be approximately $2.23 trillion to the health care budget over fifty years. It is vital to remember that physicians, in addition to being paid on average $113,000 per year, order referrals, services, tests, procedures and hospitalization. It is a rough estimate that a physician accounts for approximately $500,000 annually in total health services ordered on behalf of clients and beneficiaries. Epidemiologists, manpower and health economists, and health actuaries should examine this concept in detail and depth to develop sensible and realistic figures. One sobering factor that must be weighed is that there has been a substantial increase in the numbers of practicing physicians in the U. S. since 1965, and physicians income has risen regularly in both absolute and in real terms except for a brief period in 1974 and 1980. The ration of physicians to population has increased constantly since World War II.

The second factor causing an increase in American health expenditures is the aging of the population. There are more very old, those aged 75+, than any previous time. It is expected that in absolute numbers thoe over 85 will increase by several hundred percent in the coming decades. We will have more than a million over 85 and more than a hundred thousand older than 100. The aged are predominately female and have been, are, and probably will be in the lower rungs of the economic ladder. Although the absolute numbers of the very old will not be a large percentage of the total population, the absolute increase will have an economic impact on health services costs and distribution.

It is more expensive to treat a long term degenerative disease than it is to treat an acute myocardial infarct. It is more expensive to successfully treat cancer and then five years later to treat a reoccurence. It is strange, but total lifetime health expenditures are higher for fit, healthy people. Previuously nothing was really done for "galloping consumption" and the afflicted died rather inexpensively.

The management of neo-nates is similar. Three to seven percent of births have significant medical problems. Today it is possible to save babies delivered at less than 1000 grams but at a cost than can run to hundreds of thousands of dollars in care, and care that is often not covered by insurance. Throughout the the health system simple and relatively inexpensive deaths have been replaced through heroic intervention with extensions of life and expiration much later, but at much greater total lifetime health costs. Further, as the aged live longer, the variety of complications and co-morbidities managed or palliated becomes more extensive and more expensive.

No mention has been made to such heroic efforts as organ transplants and mechanical replacements. The issues raised by the End Stage Renal Disease (ESRD) program is but the first chapter of increased costs due to the diffusion of an experimental set of technologies based on chemical management and transplantation. The cost per year of the program is in excess of one billion for approximately 60,000 beneficieries, and the cost per year of life is in excess of $50,000 per beneficiary year. A national AIDS entitlement program will likely follow, costing billions annually.

The third factor to be considered, especially in planning for health care expenditures after the year 2011, is the 74 million Americans that will reach retirement age for two decades until 2031. This is the largest cohort born in 20 years in American experience. This group has moved through the schools, colleges and workforce with an outline that is compared to "the pig moving through the python". Its outline is evident to any that look. The major problem is that there is not a concommitant number of offspring expected in the economy to support the "baby boomer" health and retirment costs. In the 1930's 9 workers supported each retiree; in the 1950's, 6; and in the 1970's, 5. In the next centgrury the ration will go to two and a half or three to one.

Any adjustment to the health system today should address the husbanding for resources to provide for the health and retirement expenditures of this unusually large group. Perhaps special Medicare, Medicaid, Social Security and General Pension funds or programs should be encouraged thorough legislative enactments. It is possible that intergenerational tensions will peak when the "baby boomers" use a very large share of the national product for health and pension benefits and there are not sufficient resources in the American economy to meet the needs and wants of the balance of the population. A worst case scenario taking account health, retirement, debt service, international debt

service is truly cataclysmic. In this problem it is important to remember that one Congress of the United States cannot bind a succeeding Congress, and thus the "baby boomers" are currently anxious, and the real prospect of a renunciation of present health and pension programs exists.

It could be argued that it is the current high earning and production efforts of the "baby boomers" that allow for generous treatment of those now retired or disabled. It need not be a problem that is faced only in 2011 and thereafter. It is a problem that could be addressed immediately and certainly when the Medicare program is restructured in the mid to late 1990's. It could be argued that the "baby boomers" is going to pay the health and retirement benefits of this decade and the next, but that shortly after 2011 the succeeding workers in society will substantially modify, reduce, or renounce their "social contract" obligations to this cohort.

It is possible to construct a scenario where this is the only viable alternative for the society. It is difficult in a capitalistic society that is democratic and pluralistic to plan rationally for the impact that such a segment of the population will surely bring. It is not difficult to imagine the relative unavailability of nursing home beds, home care services, hospital space, hospice beds, and price escalation that such situations engender in a capitalistic society. One might send children to school on a split double daily shift with fifty students per teacher, but double shifting as nursing home is a different matter. It is possible for the health analyst and policy maker to imagine aged poverty, and health care neglect on a scale never before experienced in America. It is an obligation of all health policy makers: legislators, administrators, insurors, beneficiaries, providers and economists and actuaries to prepare for the arrival of this large population cohort. A necessary adjustment must be a slowing of health expenditure now, rather than a severe breakdown on health budgets later. Let us also start examinations of specific disease management in other cultures, particularly Japan, Canada and to a lesser extent Western European Nations.

The fourth factor concerning technological improvements such as artificial joints and joint procedures, computer assisted tomography, magnetic resonance imaging, positron emission tomography, lythotripsy, etc., etc., etc will have their own impact on the increase in health expenditures. Each technology is expected to have its own incremental addition or subtraction from the total cost of health care. It appears that the diffusion of small technological changes such as exemplified in the past by the use of unit dose pharmeuticals and disposable operating room supplies and linens may have as large an impact as do the "major" developments noted in the medical press. Knowledgible analysts indicate that their best guess on cost impact of technology has been between 20 - 30% of the increase in medical costs since 1965.

Rather than attempt to tabulate the costs associated with each technological change, it would be wiser and more practical to focus on the fact that these devices, medicines, and supplies are produced by forprofit corporate entities whose fiduciary duty to stockholders is to maximize long term stock value. It is also wise to acknowledge that these large and mid-sized corporations are familiar with the political leverage points in any government, and especially intimately familiar with the Washington lobbying process. As entities with fiduciary duties to stockholders, it must be expected that they will aggressively promote the sale of their products and services throughout the U.S. health economy, and throughout the world health economy as well.

When technology is considered, two claims should be investigated.

One is that between one quarter and one third of all American diagnostic and therapeutic procedures have no value. Second, it has been acknowledged that thirty percent of the health care dollar now spent in the last year of life often "exquisitely measures death". This policy might be moderated by governmental policy fostering changes in societal expectations, and with an amelioration of malpractice and defensive medicine problems. To expect wholesale change in long term history and experience flies in the face of reality. The multinationals in health care will continue to encourage demand, and will continue to maximize profit from the technologies, services and products developed.

Health insurors and investor owned inpatient, outpatient and ambulatory facilities impacts on costs of health services over the next several decades is unclear. Perhaps the most clearly defined problem is that corporations owned by stockholders and investors have a fiduciary duty to their owners to maximize long term profit, and that they are less likely to cost shift from one group of health beneficiaries to another, and they are likely to have a long term strategy for profit optimization. It is possible that the for "profit health" sector is more efficient and better in the utilization of health resources than the non-profit voluntary systems. It is also possible to imagine segements of the for profit sector "skimming" to maximize profit from various affluent segments of the health economy that previously subsidized the less profitable. No one really knows how forprofit and non-profit sectors of the health economy compare.

It is plain, however, that in most sectors of the health economy the beneficiaries choices are constrained either by geography, experience, policy or nature. Physicians have admitting priveleges at a limited number of facilities, usually three or fewer. Patients are limited by geographic location to hospitals and clinics in that region and that usually means a handful of primary care facilities, one public institution, and a tertiary medical center within 200 miles.

As for health insurance, it is wise to remember, as a founder of the social security system told me years ago, "Insurance companies are in business to collect money and invest it, not to pay claims." If Blue Cross and Blue Shield Associations were to completely lose their anti-trust immunity, some incremental gains in system costs would be passed to the beneficiaries. The existence of 400 health insurors, 50 state medicaid programs, and a multitude of fiscal intermediaries, peer review organizations, plus a dozen or so governmental health programs does not make for administrative efficiency. Experts have calculated that at least $29 billion have been spent annually on health care administrative costs that might have been avoided by a more streamlined and compact administrative system.

The final factors causing increases in economy-wide health care expenditures beyond the present 10.9 of GNP or $458 billion (1965) dollars can be related to: (1) natural increase in population due to net immigration and normal birth/death rations (2) legalization of up to seven (7) million illegal immigrants already within the U. S. and (3) high medical costs for care of high risk children in various minority groups. An illegitimacy rate of 50+% for Black and 40+% for Hispanic Americans goes beyond the immediate costs of neo-natology units, but to higher health expenditures throughout the life of the mother and the child/children born under such circumstances. These children traditionally use more health care services than do other more traditional arrangements where fewer birth, psychological, and physiological complications are encountered. (4) AIDS has been mentioned, and it is unclear whether this will be a problem that costs four - five billion dollars pey year for a number of years, or whether it is a major epidemic that could cost hundreds of billions for treatment, education, and research. Present ranges

indicate that New York City alone expects to devote a billion dollars per year to the issue, and the Institute of Medicine projects that by 1991 the annual cost will be in the $8 - 16 billion annual range for health, alone. No one expects the health sector to grow less rapidly than the real growth of national product.

Three non-health economic factors must be examined because they limit local, state and federal government's range of options and ability to respond to increased demands for health resources. (1) Pension liabilities in local, state, and Federal Government for military and civil service retirees and current employees are currently largely unfunded. The recent problems of the Pension Benefit Guaranty System highlight how badly the private sector is prepared to handle the pension rights of it's retirees. Steel industry claims alone are approximately 300 percent of the yearly fund revenues. It is obvious to all that have examined the pension problem that huge unfunded liabilities will have to be met or defaulted on by business, local, state and federal government. This problem tends to coincide with the health care shortfalls. (2) International debt obligations in the range of $500 billion to $2 trillion will need to be serviced because of trade problems with the rest of the world. The experts concur in the belief that the yearly current accounts deficit in excess of $150 billion in 1985 will not quickly recede, much less reverse itself. This debt must be serviced at the international market lending rate and this outflow further reduces economy wide options for other resource allocations, as well as a further drain on savings. (3) A national debt at $2.3 trillion dollars currently requires in excess of $125 billion annually to service interest charges, alone. No one can see the debt being realistically reduced, and one can expect the $3 trillion mark being passed by 1995 or during the next economic downturn, whichever comes earlier. (4) Finally, no one expects the proportion of GNP devoted to national defense to significantly decline from the 6 - 8% of GNP , nor does anyone have realistic expectations for reduction in national education, housing, agriculture, airport, and smaller regulatory and infrastructure programs.

The real concern is not the next decade, which will have its own problems, but rather the decades beyond 2011 when the confluence of the factors discussed here are realized. All these would be manageable were there normal populations in the workforce to provide the foundation funding, but this appears impossible at this time.

The supporting workforce is already largely present and their numbers do not appear sufficient to support an increasingly larger portion of gross national product devoted to health, pensions, national defense, international debt service and governmental debt service as well as the basic governmental and infrastructure programs.

If a worse case scenario is considered, it is possible to project in excess of 17% of national product being devoted to health by the year 2005. Even a best case scenario, where the historic rate of health care cost increases was half its historical twenty year rate, one would expect that the proportion of national product devoted to health would increase by 1.1% of national product per decade. This would bring the 2005 best case of 13.0% Translated into real numbers, best case, this means in 1996 $504 billion would be expended on health in 1985 dollars, and in 2005 approximately $550 billion 1985 dollars would be spent annually. If one extrapolates the dollars spent today on federal health programs, assuming no major programatic changes, this would mean that Medicare A would receive approximatley 16% of that increase; Medicare B, approximately 6.5% of the increase; and Medicaid approximately 7.9% of the increase.

In total the Federal share of the health dollar has been about 29% of total health expenditures, the states represent approximately 12%, and the total Federal and State share is about 41% of the health care dollar. Sometime, a calculation of tax expenditures, employer administrative expense for Federal health program, and insurance loading costs associated should be tabulated.

POLICY DECISIONS: PRESENT TO 2000

The decisions between today and the expected depletion of the Medicare trust funds are: (1) Do we want to continue the present pluralistic health system or do we want to adopt/accept another model? (2) Do we want to patch and "retread" the present system with mandatory employer insurance coverages? voucher systems? rates with extensive regulations, severity, and exceptions? extensive peer review and quality control programs? state insurance pools for the "presently unisurable"? all of the above? etc. etc. ect..

Preliminary calculations show that health expenditures in excess of 15% national product are not sustainable for long periods for the American economy in the situation that it presently finds itself. Health expenditures, particularly for the elderly, must be considered "consumption" as opposed to "investment". It is clear that the combination of 15% spent on health; 6 - 8% spent on national defense programs; debt service on three trillion dollar national debt; and foreign interest service on accumulations of international debt must put the economy at a disadvantage with other industrial nations and with some advanced developing economies. Of the four or five categories listed above, the only ones really susceptible to reduction by policy changes are health and defense, and if health and defense were to be reduced proportionately, health would need to take two-thirds of the proportionate reduction.

Put another way, it cannot escape the economist that U. S. health costs, as in automobile manufacturing, are higher on a comparative basis than the total hourly costs in countries such as Mexico, Korea, and Taiwan. In Mexico and Korea, hourly wages in 1985 were as low as $.72/hour in Mexico, and $1.90/hour in Korea.

The Canadian example offers some advantages for a U. S. comparison because of cultural and language similarities. Appendix A shows the selected statistics for comparison. Also it is not quite as "socialistic" as many European health systems. The adoption of a Canadian system results in two major items for health cost savings. The first is the reduction of financial and budget associated paper flows between providers, beneficiaries and the intermediaries and the payor, savings from which are estimated to be at least $29 billion per year. The U. S. network of Blue Cross and Blue Shield Associations; Fiscal Intermediaries of the Governmental programs; 50 state Medicaid Programs; Indian, Military, and other government health programs; 400 plus health insurance companies; plus an assortment of Health Maintenance Organizations, Preferred Provider Organizations, etc. is an "boulibasse". Further, the U. S. preoccupation with malpractice and "defensive medicine" is estimated to cost more than 15% of the total expended, and one has heard estimates as high as 50% of hospital costs being tied to "defensive medicine".

The problem with adopting a "Canadian" style system is that the insurance companies and many others make money from the present system, with the excess costs being passed on to the payors: be they the employer, the government, the taxpayer, the

beneficiary, or the indemnity insuror. Vested interests also benefit from the continuation of the present tort/malpractice arrangements. Reasonable analysis would show that if we, tomorrow, were willing and did adopt a "Canadian" style national health insurance system with one government insuror and one set of policies and procedures, we would have hundreds of thousands of mid and lowerlevel administrative workers with no real function located throughout the health system -- in doctors offices, in hospitals & clinics; at insurance offices and in insurance companies, at data processors, and in government. No one knows what the bulk of these claims and information transfer personnel contribute to health care of the beneficiary, but one does know that $29 billion annually probably pays for something like a million workers. A million workers who could productively be used elsewhere, though retraining and dislocation program costs would be substantial.

PROSPECTIVE PAYMENT -- DIAGNOSIS RELATED GROUPS

This recent effort, that of prospective pricing in Medicare Part A and some state Medicaid and nursing home, and a handful of "all payor" hospital programs, has a mixed history . After an initial "notch" of reduction and rationalization of the health service process. The rate of increase in health care costs charged to the government appears to continue at a rate substantially higher than the comsumer price index, or even the more generous medical economic index. No severity of illness index has been installed across the nation to discriminate between levels of complexity and intensity of resource use.

The Peer Review Program (PRO) established almost simultaneoulsy has been lagging due to a variety of regulatory, budgetary, and political complications. It does not appear that the political will to do the deep and complete analysis that would be required for a true "product line management" system; to develop, implement, and enforce Peer Review Standards of a National PRO progam that would eliminate or reduce much of the malpractice potential.

It appears that the inclusion of hospital based physicians in radiology, anesthesiology, and pathology in the PPS/DRG system is years away, if ever, and that the regional and geographic variations of medical practice and cost are very difficult problems for a capitilistic political system to address.

It appears that the medical communities major players: the Medical, Nursing, Hospital, Medical Education, Equipment Suppliers, and Insurors insist on the application of constituency power to block or slow changes to a more efficient system. If the major players insist on a perpetuation of the present system , a rate of health care costs increases that is half of the historic rate of increase for the past twenty years is not achievable.

PEER REVIEW, UTILIZATION REVIEW AND QUALITY ISSUES.

Peer Review issues are intimately tied to health care economic, policy and philosophy issues: (1) product line protocols will eventually be defined on state, regional, national and eventually international levels, at least among the advanced developed nations. (2) the division between "art" and "science" in medicine will be more clearly delineated, with the result that the missing "theory of medicine" will become more and more systemically defined. (3) peer review must be available to counterbalance the

tendency of a prospective payment system to discharge earlier and treat less aggressively. (4) Finally, the functions of reduction of variations in medical practice and incidence of questionable medical actions are natural roles of this process. Peer review can be expected to increase in budget terms as more and more payers of different stripe and persuasion undertake the examination of the details of medical management. Currently, the PRO budget for Medicare A is approximately $154 million per year, with approvals suggested for an increase of $67 million in the OMB mill, with another $33 million on request. Peer Review requirements mandated by Congressional action signed into law in the various budget reconciliation acts have substantially increased the scope of work in the 53 contracts initially negotiated in 1984 & 85.

An issue that must be focused on is the involvement with, and participation in, the peer review process by the American Medical Association. A second major issue that has not been addressed is the combination of financial data with the medical data, and the development of "longitudinal" analysis of health care on some statistically sound basis. Confidentiality is an issue that keeps coming up. The release of data and its impact on institutions and the privacy rights of individual patients is a concern and a problem for management of health care. It can and has been used as a "straw man" to block progress, analysis, and development of health policy.

QUICKER & SICKER

The quality issue of "quicker and sicker" will be with the system as long as efforts are made to control cost. For twenty years cost reimbursement made for medical and administrative health practices that did not measure benefit in relation to resources employed. Once you begin measuring resources employed and weighing against benefit received, it is inevitable that those individuals receiving fewer services or services in a different setting will complain. For example, if the average acute care length of stay drops from eleven days to seven, what would one expect in either nursing home, home health serice, or visiting nurse service than clients that are not marginally as well, ceteris paribus. It does seem to make sense to shift care to a site where daily cost is lower, rather than the acute care setting where average medicare costs per day exceed $500 nationwide, and $800 in many localities and institutions.

Quality control issues have a potential for better management at individual institutions. The more clearly an institution is aware of its patient mix including the severity of their illness, the better it can plan for long term management of the institution. Put another way, quality control and utilization review internally are part of a product line management system that have historically yielded a return to management from the investment. The gains are not only internal, but also in customer assurance. It would be wise for many providers to move ahead with quality and utilization programs in advance of government mandates just because it is good management, and will assist in problem identification, resolution, managment control, and beneficiary and third party payor confidence. One wonders what an apporpriate level for this activiy might be, but is is certainly larger than the $130 to $250 million currently allocated for such activities by HCFA from the Medicare insurance funds. Experts indicate that 3 - 5% of gross revenue is not uncommon in industry for such purposes. This figure would translate to $13 billion annually in health care. Another problem that has not been addressed is the hidden cost and the difficulty of adequately measuring the resources of all the players in the peer review, quality and utilization review efforts at the different levels. It is safe to say the amounts formally earmarked for such program

are much less than the total resources expended. Efforts to identify total costs of quality and product line management need to begin.

CONCLUDING POINTS: RARELY CONSIDERED

I would like to conclude this paper with three simple items for consideration that are rarely mentioned, though each of us intuitively knows their importance and significance in policy formulation: (1) the distribution of physicians, nurses, and hospitals by congressional district; (2) the implied requirements on a physician and practice to support an average physician income of $113,000 annually, (3) some practical ideas that must be considered in the national debate to modify and restructure American Health Care.

DISTRIBUTION ISSUES: CONGRESSIONAL DISTRICT

If physicians, hospitals and nurses were distributed uniformly across 435 Congressional Districts (and they are not even remotely evenly distributed) the following would be true: approximately $1.053 billion would be spent for health care in each Congressional District annually for each districts approximately 525,000 inhabitants. This is: $484 million for hospitals; $232 million for physicians services; $94 million for nursing homes; $84 million for drugs, $73 million for dentists; and about $94 million for miscellaneous NEC than health insurance, education and "tax expenditures". These constituents are served by eleven acute care hospitals and approximately four specialty or government hospitals. Each district has approximately 1,225 physicians, 3218 registerred nurses, 1300 practical or vocational nurses and an assortment of pharmacists, administrators, therapists, and other allied health personnel. There are 3198 counties or independent cities in the U. S., which makes for an average of approximately seven per Congressional District. The average hospital in this hypothetical district has between approximately 100 beds, with 174 physicians on staff due to duplicate staff priveleges. There are 127 medical centers that serve as tertiary care centers across the nation, and these must be described as medical and economic behemoths. Associated with these medical centers are approximately 450 Council of Teaching Hospital Institutions. The important economic and policy point to consider is that the smaller hospitals make up more than 50% of the total number of facilities, but they take account of only 14% of the patient days/revenue. The corollary is true for the medical centers and Council of Teaching Hospital Facilities. They make up about 10% of the institutions but have a much larger proportionate share of both dollar and patient days. The group of facilities represented by the American Association of Medical Colleges are truly the giants of American Medicine. Further, since their staff is often faculty, resident, and highly selected attending physicians, they do not have the problems of physician management that are sometimes associated with the smaller suburban and rural facilities. These institutions also account for the lions share of medical research funds; funds that total $4 - 10 billion annually from Federal, State, philanthropic and foundation sources.

Each constituent has the choice of between one and three hospitals for immediate acute care, and virtually all, by virtue of interstate highway or air medical service, have access to secondary and tertiary care referral centers. Most physicians have admitting priveleges and staff obligations at between one

and six or seven institutions. I suspect, though studies have not been published, that the average physican in private practice has priveleges at two or three institutions in a limited geographic area. Those with more than three staff appointments would be rare. Other than the non-profit voluntary, or the investor owned facilities, each constituent has access on some basis to a public or county hospital. There are approximately 900 county hospitals with 75 of them located in large cities, and the balance in small towns or rural areas. Beneficiaries are restricted in their choice of hospital to (1) those where their physician has admitting and staff priveleges (2) those in their geographic or service areas and (3) to a smaller number of public hospitals and to referral centers. The average physican in private practice has staff priveleges at one or two small hospitals to which he owes primary allegiance. Perhaps he also is allowed to admit to a public hospital,often a hospital of last resort though their staff is often salaried. He is not likely to have a clinical appointment at a tertiary care or teaching hospital.

The point of this discussion is to point out that medicine has some of the qualities associated with a public utility with restraints for the beneficiary on the basis of geography and bureaucratic privelege. A patient cannot go to any physician seeking treatment at any facility. A patient usually goes to the physician that has been treating him/her, and then is referred to the hospital where that physician has priveleges. A beneficiary can make alternative choices, but often at great expense, without guidance, and often requiring the acceptance of a new physician, outside the area of his/her domicile.

PHYSICIAN CHARACTERISTICS

Another factor should be considered when taking into account the relation of beneficiary - physician - hospital - third party payor. Physicians are very talented. Their earnings are in the top percentile; they are in the top social stratum of their society and have always been. They were academically excellent in secondary school, and in college. They have been trained for four years in medical school, and in a residency of three or more years. They see hundreds of sick monthly and thousands in a career, and are rarely at a disadvantage with their clients. The hospital depends on physicians to admit patients, and key players in several hospital departments are often physicians. Physicians network with each other very well.

Insuror's pay claims on the basis of experience, and they are not inclined to "haggle" if the increased cost can be passed to the beneficiarey, government, the employer, or to the insurance purchasor. Altogether it is a system that favors the physician, the institution, the insuror, and does not take into account the wishes of the patient. The patient is generally inarticulate. When the beneficiary has input, it is often transmitted through his physician, and occassionally the hospital.

The dominant player in state and national health policy debates about American Medicine is and has been the physician for at least fifty years. When we look to modification of health policy, it is to the physician that these modifications must primarily be addressed and whose favorable response is critical in any reform. There are exceptions, there are methods by which this is occasionally overcome, but for the average person, in the average place, with the average disease, the physician manages and directs the employment of resources. Why is this? What underlying economic, political, and social realities cause the physicians to be the drivers of the health system?

FACTORS: PHYSICIAN POLICY DOMINANCE

Several important facts follow from the organization of medicine. By "organization" we mean those choices made through time that formed the policy and economic structure within which the medical professions practice. Ours is a pluralistic, free enterprise, mixed capitalistic-socialistic economy governed by a tri-partitate Federal national government in concert with smaller units of government. Much medical and insurance regulation comes from the 50 state governments, and the three big Federal insurance programs. Remember that 22 cents from each health care dollar goes to physicians. That number itself totals approximately $101 billion in 1985. This is not income, but rather approximately gross physician receipts. Average physician income was calculated to be $113,000 in 1985. This $101 should be compared to $211 billion for hospital, $41 billion for nursing home $ 36 billion for drugs; $32 billion for dentists; and $36 billion for other personnel services & supplies. Omitted from this calculation are funds spent for health insurance administrative expenses, investment in medical education; and costs associated with employer & government insurance administration as well as "tax expenditures" due to the deductibility of employer paid premiums, and other medical tax deductions.

In most settings the physician directly or indirectly dominates the encounter. Physicians are organized in more than 200,000 small businesses, 120,000 in primary care alone. No guarantees are given that any patient or referral will be given today, tomorrow, next week or next year. Physicians depend on each other and the hospital to care for the client beneficiary. The very organization of the network of small businesses insures that changes to a "status quo" that has provided for its members an assured high income is not likely to be undertaken quickly, easily,or without expression and examination of real and imagined problems with a potential for anxiety. It is no surprise, after fifty years of experience, in the present economic situation, to find physicians resisting movements to change and rationalize the practice of medicine. Much physician behavior recalls the "Luddites and the looms" of 18th Century England.

Physicians can't even agree among themselves what appropriate levels of compensation should be between and among their specialty groups, between academics and practices, between practice based and hospital based, between urban and rural, and between "cognitive" and "procedurally" oriented specialties. Couple this with the already experienced expansion in the number of physicians, plus the expectations of 630,000 practicing physicians in the forseeable future and one sees the root of professional intransigence absent any threat of increased Federal presence in medical economic issues. Faced with proposals of major changes on Federal payment programs, the fears and intransigence escalate. Forgotten is the fact that Medicaid and Medicare Part B substantially increased payment to physicians, providing payment for services previously provided without compensation. Twenty percent of gross practice revenue, or something like $35,000 annually, comes from Medicare and Medicaid physician payments. Medicare B payments alone total 24 billion in 1986 and that does not include deductibles, co-payments, and balance billings allowed. The total of $24 billion divided by 460,000 active physicians, yields $52,173 per physician. Someone gets the money!

PRACTICE ECONOMICS: TO SUPPORT 113,000 INCOME

ASSUMPTIONS:

50% NET OFFICE OVERHEAD; 2080 TOTAL SCHEDULED PRACTICE WORK WEEK HOURS; 160 HOURS ANNUAL LEAVE; 88 HOURS NATIONAL HOLIDAY TIME; 96 HOURS AVERAGE SICK LEAVE; ATTENDANCE AT FOUR CONTINUING MEDICAL EDUCATION MEETINGS; BAD DEBTS 15% GROSS BILLING; AND 7% DONATED CHARITY CARE; 40 HOURS ANNUALLY IN HOSPITAL AND PRACTICE STAFF ACTIVITY & MEETINGS.

AVERAGE SOLO PRACTICE PROJECTIONS

Total hours for practice	2080	
Annual leave/vacation		160
Holiday Time		88
Professional Meetings/CME		64
Average Sick Leave		96
Hospital staff & peer review		40
Sub Total	(448)	
Bad Debt (15%)		312
Charity care (7%)		145
	(457)	
Hours	2080	905
Regular revenue hours	1175	
Practice income 50% gross income	226,000	

192.34 hour or $46. per quarter hour time increment.

The end result is that approximately 1632 hours of patient contact, with 1175 paid revenue hours, result in the necessity for a charge of $46 per 15 visit/time increment to support income of $113,000 year for those that actually pay their bills. There is great variation on this theme, but it is not unrealistic, and is employed for exposition purposes only. No account is taken for weekend, after-hours work, procedural income, coverage, and group practice divisions. What is clear is that a physician probably must have a client base in the neighborhood of 1000 to 2000 patients to support 1600 hours of yearly practice experience. One must remember that on the day a practice opens, no patient is assured, and that economic viability is slowly built. Once built, of course, this client base offers both economic, practice and political stability to the practitioner and the profession. Physicians are sure only that people will be born; that they will be sick and injured, and they will ultimately expire. No patients are guaranteed.

POLITICAL PARTICIPATION: PRACTICE & POTENTIAL

Several important consequences flow from the organization of medicine. Most important, with an average income of $113,000 per year, it is possible for physicians and their families to be active in the State and Federal elective campaigns. Imagine the impact of two or three groups of several hundred physicians and their wives contributing $1000 each to the Congressional District primary and general election campaign. With 1225 physicians per district, on average, they can effectively fund a viable challenger in any Congressional District. Though they might not cause their candidate to be elected, or even to be nominated,

let me assure you that the potential of a "war chest" of several hundred thousand dollars certainly gets the attention of the party and of any incumbent. Ten or twenty such challenges around the nation would have measurable policy impacts. It has never been done, but it could be.

The Medical and Dental professions have not exploited this potential to date, but they could. However, their PAC, "In Kind", "soft money" and "independent expenditure"other efforts are not unnoticed. There are many state AMA-PACS and no collective data are readily available. Federal PAC data show that five of the top ten non-affiliated Political Committees are the AMA, the Texas, California, New York Associations and National Dental Group. The average AMA member contribution of $35 has accounted for an accumulation of several million dollars, and the ability to do independent expenditures for selected races to the extent of several hundred thousand dollars.

The potential for political influence in a Congressional district is through contact with the medical beneficiaries being treated. With exposure to between 1000 and 2000 people per year, the 1225 physicians in a given district have effective avenues for the dissemination of their political views not open to other groups. Further in this encounter, the physician's advice, belief and request has more credence and impact than other professional groups. Physicians spend their lives advising people, and learn the techniques of effective advice giving as a part of their professional training. Finally, physicians have been in a variety of leadership and organized committee groups.

They have been exposed to rigorous scientific and social training. They substantially control their own schedule and have a network of referral and professional contacts in any given geographic area. Were physicians to choose to do so, in a decade they could elect dozens of members to Congress, and shortly therafter it would be possible to take over health policy positions. It is the prospect of increased physician political involvement over the past fifty years that has allowed them their preeminent position in the setting of health policy. The prospect of direct, organized, orchestrated long term involvements by physicians in Congressional District Politics is enough to strike fear in the heart of the professional politician.

REFORM: PRINCIPLES & REQUIREMENTS

Some ideas that should be considered in reforming American health care system policy are:

(1) Grandfather economic rights. Assure the physician community that their collective income will not be smaller than it is today, and protect them with an inflation escalator, plus adjustments for population growth and real GNP growth.. This seems generous, but had it been applied since 1965, national health expenditure would have been substantialy lower annually, and the aggregate savings would be several hundred billion dollars for the federal treasury alone. These savings occur not from reduced physician income, but from reduced demand for hospitalization and use of all other medical services.

(2) Change the present system of first dollar coverages, deductibles and co-payments, to one where beneficiaries pay substantially all of his/her family routine and normal expenses up to some indexed annual and lifetime limit. Employ vouchers for the impoverished or elderly, and allow credit to individuals for the unused portion of the yearly credit on some sort of multiple year rolling average. Somewhere we must recognize that economi-

cally the aged are not better off in 1985 than in 1965 when the Medicare/Medicaid program was established. Then approximately 15-20% of aged income was committed to medical care, and in 1985 this proportion was again reached and exceeded. The benefit has been more extensive and intensive service, and perhaps an extension of life expectancy of 3 - 5 years. Many would make causually connect the growth of health expenditure as a proportion from 5.3% to 10.9% GNP as a direct consequence of the establishment of the Medicare/Medicaid Programs.

Perhaps the limit should be $1500 for an individual and $2500 for a family yearly, and 75,000 lifetime before Federal Catastrophic Health Program benefits are triggered. When such a program is constructed, it is possible to include inflation modifiers, rolling average concepts, and life-time expenditure accounts for both payment and benefits employed. If such a program were constructed and employed, the government programs would then pay when limits are reached. For the individuals truly unable to pay, the government could develop a voucher system to pay for services. Perhaps even children could be included in a voucher program, with lifetime accounting to allow for payment of medical services after a given age, such as 25, is attained.

The possibilities are limitless. It should be remembered that individuals could still buy any variety of insurance policies to insure against this first increment of yearly medical services, and lifetime and catastrophic risks. Sometime, it must be remembered and emphasized that if 242 million people spend $456 billion dollars annually for health care, that the $1892 spent annually comes from the society, all its members. The question that must be addressed by policy makers is who is to pay the funds, and who is to receive them, and finally, what can be done to decrease the absolute real level of expenditure.

Absent the ability to decrease the expenditure to minimize the rate of increase over the long term, the present health inflation will continue. The present system is characterized by being the worst of "socialized medicine" and capitalism. It is difficult to visualize a system where more health resources are used; where the rate of increase in payment for those services is faster; or where there is more paper generated in administrative processes. Not only has the proportion of the national pie used for health care doubled in twenty years, but the pie was already much larger than any other in the health care world.

One wonders when the cost spiral will cease, and what will bring its halt. Nothing appears on the economic or policy horizon presently other than the limit of the society to tax and the willingness of employers to pay and a comparison of health program expenditures compared against other programs such as Defense, Education, Housing, Agriculture, and Debt Service. Political realists know that the $1892 spent per person for health care in 1985 will not be reduced, the best that can be hoped for is to slow the rate of increase.

The policy questions for the next several decades will address the question: How is the $1892 and any real increase to be distributed between long term borrowing, employers, taxpayers, and beneficiaries. No one else is going to come forward and volunteer to shoulder the burden. The debate in U. S. health care has really been over who receives how much of the $1892 spent each year for each of us. That fight has little to do with health, and much to do with politics, economics and the exercise of power.

INITIATIVES: OTHER MAJOR AND MINOR HEALTH PROGRAM POSSIBILTIES

(1) Modification of health program tax incentives to employers and employees to encourage "self insurance" rather than first dollar coverages, deductibles and low co-insurance program. Encourage catastrophic coverages rather than first dollar.

(2) Modification of medical tort system to a "no fault" workmens' compensation model with concommitant development of health professional sanction, arbitration, licensing, and continuing education and certification program.

(3) National licensure of physicians and other health professionals by specialty, subspecialty, etc. Education requirements

(4) Revision of medical education program to reduce financial hardship and investment by the professional, with costs shifted directly to Federal Budget with concommitant ability to foster development of primary specialties and discourage development in surplus categories.

(5) Division of physician community into three groups; (1) capitation for "gate-keeper" primary care physicians. (2) Hospital and procedural oriented physicians to be paid on relative value basis. (3) non contact physicians to be paid of "episode of illness" basis.

(6) Development of contractual arbitration on a voluntary basis to commit practitioner. provider and beneficiary to settle malpractice disputes quickly, inexpensively, and fairly.

(7) Contribution to malpractice system developed on basis of past premium experience paid by practitioners, and supplement from beneficiaries, insurors, and government on a capitation basis in a "Trust" fund.

(8) Development of hospital based insurance for procedures performed in hospital by professionals such as surgeons, obstetricians, etc. Division of professional malpractice into hospital and non hospital settings.

(9) Development of industrial engineering computerized standard disease management protocols, procedure costing system and mandatory uniform accounting system by hospital size grouping.

(10) System of Mandatory Assignment of government and private insurance benefits subect to income level tests to hospital, nursing home, and physician after beneficiary payment "theresholds" are met.

(11) Publication of national, state, and regional health, program statistics in an organized manner to reflect differences in the occurrence and diagnsois of disease, and if managment of disease. Focus on unexplained variation, and outcome analysis. Developement of national computer data transmission and information exchange standards.

(12) Aggressive and uniform peer review with resources devoted to the measurement and reporting of outcome measures.

(13) Utilization of standardized uniform staffing methodologies for the employment and staffing of health care facilities, departments, and programs.

(14) Incorporation of Public Hospital, Veterans

Administration, Department of Defense, and Indian Health Service programs into a single system for health management.

(15) Development of a Military Health Reserve program to provide for medical services to armed forces in time of war, with voluntary service available for peacetime troop and dependent support both in the U. S. and abroad.

(16) Development of physician manager administrator program to administer medical facilities, particularly moderate and large hospitals, 200+ beds.

(17) Development of state health planning program to encourage, foster and reward rational development and placement of major health facilities. With payment to state directly for capital projects for redistribution to selected facilities to encourage optimal placement and to reduce inappropriately located health facilities.

(18) Development of computerized individual lifetime health accounts and records to record and account for health resource employment.

(19) Development of longitudinal health data collection on an individual basis to track disease and co-morbidity and assess varied treatment methodologies, standards, regimens and protocols.

(20) Participation in and development of international comparisons in disease incidence, expense, management and outcome.

(21) Development of an non governmental national independent free standing health economics and computer research center.

(22) Analysis of costs and benefits associated with a Nationwide Single Health Insurance Program similar to the Canadian National Insurance System.

Undoubtedly some of these suggestions are not internally consistent; some conflict with each other. Reasoned analysis of each proposal should be attempted. There are marginal benefits to be gained from each of these modifications. The health community has just begun to do the analysis that a for profit industry would have undertaken as a matter of course. Health continutes to be a cottage industry. Great gains could be achieved just by the continued sampling of institutions to determine their profit levels, and to assess their varied performance both before and after the transition to Prospective Payment for Hospitals. Product line definition and costing is in its infancy. Peer Review is just barely underway. There are wide variations in practice patterns and reported incidence of morbidity. No one has touched the subject of medicines, procedures, and treatments that appear to have little or no medical efficacy or treatent value. No one has begun longitudinal studies on a scale sufficient to do reasonable cost-benefit and outcome measures.

CONCLUSION

The present efforts in Prospective Payment for Hospitals have yielded some return as evidenced by the later date for expected program insolvency. Moderate estimates of budget savings of $10 - 15 - 20 billion since program inception are defensible. There is a long way to go. A relative value scale system for physician payments should dampen the increase in Part B payments that have risen from $12 billion in FY 83 to $24+ billion in FY1967. Serious questions are still to be settled about how to control for volume in any physician payment program. Particularly in the

case of hospitals, four years of experience has not shown an overall cost decline in the U. S. health system. The most damning statistic is that year to year health cost inflation has continued to be substantially higher than CPI or GNP deflator figures, sometimes a multiple.

Inflation in healthcare has been slowed, but not to the extent that one would have hoped or expected. Perhaps the best that can be said is that Hospitals have begun the process of product line definition, management, and cost examination. Standard system wide costing in health care is not here. We are still using provider charges as a proxy for costs, and that is a very very poor proxy. Inclusion of hospital based physicians in Prospective Payment is years away.

No one has been able to measure the extent and impact of the costs, benefits, and savings resulting from the shift to ambulatory centers, and outpatient services. No one can forcast the impact that the For Profit Investor Owned facilities will have on health care costs and services. Perhaps the most frightening recent development has been the sale of a portion of Hospital Corporation of America to is Employee Stock Ownership Trust. Can one imagine hundreds of hospitals owned by a handful of administrators, investors and physicians, and having them skin and cream for maximum profit in those small areas/regions where they are likely to h. e monopolistic or oligopolistic powers? Severity scales have been discussed since 1983, and nothing appears to be ready for nationwide installation. There has been a shift from rural and public city facilities to suburban and major medical centers. Will these "winners" disgorge any of their windfall profits? Is the political system powerful enough to take on the 137 Medical schools and 450 Council of Teaching Hospital Institutions?

For physicians, relative value scales on a national basis modified by local multipliers and adjusted for labor cost and malpractice premium experience will result in a dampening of variation. However nothing can be done to the linear increase that is projected in going from 460,000 active practicing physicians to the expected 630,000 in 2035. Perhaps these will bring some semblance of service to many underserved areas, and perhaps there will be more price competition among them, but the scenario is fraught with economic danger. The increase is a 36.9% cumulative growth between 1985 and 2035 on top of a growth that has been 27.8% since 1965. If American physicians were paid at the OECD average, their cumulative income would be some $34 - 40 billion lower annually. What can be done to control volume in a capitalistic free enterprise medical system where health care is regarded as a right and the government is the payor of last resort? No one knows, but we do know that the past history has not been very satisfactory.

No one knows the content of the tables in Appendix C "Government Program Health Statistics". The accounting and reporting system for Medicare Parts A & B is incredibly poorly designed, and not designed for analysis but rather Federal Financial Reconciliation. An immediate next step should be for ProPAC, HHS, HCFA, OMB, CRS, CBO, OTA, IOM, GAO, AND the Congress Budget and Appropriations Committess to complete the table and make estimates for "out years", and years were no data is yet available. At the moment the division in Medicare Part A is such that no one really knows the impact of policy changes in any but the most gross measures.

PREDICTIONS

Five years from now, in 1992, after relative value units have been completed, attempted and analyzed; after the Medicare and Medicaid HMO, PPO, CMP program is matured; after Peer Review is fully applied; after a reliable and administerable severity index has been installed; and after a method for hospital cost data collection is in place, I predict that yearly health inflation will still be larger than the consumer price index by approximately 30%. Governmnet program health costs will be rising by the CPI plus $ 3 - 6 billion, annually.

There are too many forces that benefit from increased health expenditures for the rate of increase to be checked. There is no effective device or program to control the marketing or pricing of new technologies, drugs, hardware, procedures etc. whether they have efficacy or not. Further there is very little prospect of controlling physician services' volume when there will be substantially more of them, and they control the beneficiaries perceived need for therapies, referral, revisit, hospitalization, and procedures recommended and performed. A capitalistic society where health care is a "right" and "entitlement" has not developed any effective mechanism to adequately adjust and check physicians' practice patterns.

Utilization review, Peer Review and other Quality Assurance programs have their potential, but operating on the "lowest common denominator" with limited organized Medicine support principle in a society that is acutely aware of malpractice is a next to impossible task. Items such as second surgical opinions, disallowance of assistant surgeons, dampening of regional variation in fees and style of practice also have potential, but the aggregate net savings from such efforts are likely to be relatively small, $5 - 10 billion annually at best.

The real hope for modification of medical practice lies in two areas: (1) increased beneficiary payment for all services out-of-pocket up to substantial pre-established limits, and (2) computerized case and treatment management standards along product line industrial principles. Absent such changes or some other unexpected breakthrough, it is apparent to all that closely look at population, physician growth, ageing of population, technological issues that it is likely, when medical expenditures pass 15% of Gross National Product and do not decline that the government take over the health system.

The real question for all the players in the next decade is: Can we agree to act together to forstall such an event. My conclusion is that cooperation to achieve such goals is not likely in a system of 12 government programs, 400 health insurors, 35 medical specialties, 50 state medical associations, and a plethora of other health professions and industries. There is no vehicle present that will allow for long term system redefinition and redevelopment, so most likely we will go along until the pain is too great, and the Congress and some special Commissions decide that no other alternative is financially viable.

I leave you with this thought:

> "When you think about it - in all these managed health care systems: HMO, PPO, CMT, IPA, etc., how is the beneficiary treated differently than he/she would be under any of a variety of National Health Schemes but at a lowewr administrative, marketing and "loading" cost? Could it be that these programs are distinctive without differences except higher costs? Aren't HMP, PPO's, CMP's miniature regional National Health Insurance Schemes?"

APPENDIX A

ITEM	UNITED STATES	CANADA
POPULATION SERVED	242,000,000	25,500,000
DOLLARS SPENT ON HEALTH (PER CAPITA)	1892	1340
GROSS EXPENDITURE (BILLION US DOLLARS)	456	29.5
NUMBER OF MEDICAL SCHOOLS	128	16
MEDICAL STUDENTS	66,604	7360
PROPORTION GNP ON HEALTH (1985)	10.9	8.6
PROPORTION FROM PUBLIC	41.4	98
COVERAGE DIFFERENCES (GOVERNMENT PROGRAM)	LTD NRSG HOME	NURSING HM
TOTAL NO. MD'S	545,000	44,230
MD'S PER 100,000	198	211
ESTIMATED ADMIN SAVINGS	-29.2 BILLION	NA
URBAN/RURAL DIVISION		76% URBAN 24% RURAL
AVERAGE MED SCH DEBT	25,000 PUBLIC 36,000 PRIVATE	
MORBIDITY & MORTALITY		
WOMEN		76-77
MEN		69-70
INFANT MORTALITY	12.6/1000	9.6/1000
NEONATAL MORTALITY	20.0/1000	17.5/1000
PHYSICIAN INCOME	113,000 ANNUM	
GENERALIST		78,400
SPECIALIST		112,000
BALANCE BILLING	ALLOWED	NONE

APPENDIX B

AVERAGE NOMINAL ANNUAL OUTLAY GROWTH RATE
(Courtesy House Budget Comm Staff)

	1975-85	1980-85
Medicare (total)	16.6	14.9
Part A	16.1	14.3
Part B	18.5	16.2
Medicaid	12.6	10.1
Food Stamps	9.8	5.1
Supplemental Security Income	7.2	8.6
Social Security	11.4	9.8
Military Retirement Pay	9.7	5.8
	1975-85	1980-85
Subsidized Housing	17.0	17.2
Net Interest	16.7	19.8
Social Service Grants	3.0	-.1
Veterans Pensions (means tested)	3.4	1.4
Unemployment Compensation	2.4	-.8
Student Financial Assistance	17.0	8.6
Aid to Families with Dependent Children	5.4	4.5
National Defense	11.3	13.5
Consumer Price Index	7.2	5.5
Gross National Product	9.6	7.9

APPENDIX C

HEALTH EXPENDITURE TABLE: PPS/DRG

Item	FY	84	85	86	87	88
MEDICAID	$K					
	$N					
STATE SHARE	$K					
	$N					
MEDICARE B	$K					
	$N					
BENEFIC CO-PAY	$K					
	$N					
PPS/DRG PAYMENTS	$K					
	$N					
BENEF PAYMENT	$K					
	$N					
WAIVER STATES	$K					
	$N					
EXEMPT UNITS	$K					
	$N					
CAPITAL	$K					
	$N					
DIRECT MED ED	$K					
	$N					
INDIRECT MED ED	$K					
	$N					

	FY	84	85	86	87	88
DAY OUTLIER	$K					
	$N					
COST OUTLIER	$K					
	$N					
DIS PROF PAYMENTS	$K					
	$N					
ESRD PROGRAM	$K					
	$N					
PEER REVIEW	$K					
	$N					
ADMIN	$K					
	$N					

	FY	84	85	86	87	88
MEDICARE A TOTAL	$K					
	$N					
DAF REQ						
DAF ACT						

MEDICAR
TOTAL $K _____
$N
YEARLY
% INC _____

PROJECT
SAVINGS $K _____
$N
CUM
SAVINGS $K _____
$N
GNP DEFL _____

MED INDX _____

CPI _____

NNP $K _____
$N

GNP $K _____
$N

RECAPITULATION

ITEM	FY	84	85	86	87	88
MEDICAID	$K					
	$N					
OUTLAY GROWTH	$K					
	$N					
MEDICARE PART A	$K					
	$N					
OUTLAY GROWTH	$K					
	$N					

	FY	84	85	86	87	88
MEDICARE PART B	$K					
	$N					
OUTLAY GROWTH	$K					
	$N					
OTHER GOVERNMENT HEALTH	$K					
	$N					
OTHER HEALTH	$K					
	$N					
TOTAL HEALTH	$K					
	$N					
ANNUAL OUTLAY GROWTH	$K					
	$N					
GROSS NATIONAL PRODUCT	$K					
	$					

Statement of the

American Society for Gastrointestinal Endoscopy

The American Society for Gastrointestinal Endoscopy (ASGE) is pleased to submit its views on possible ways in which Medicare outlays may be reduced to meet budget reconciliation targets in Congress. ASGE will also respond to recommendations of the Physician Payment Review Commission. ASGE is an organization of about 4,000 gastroenterologists and surgeons who specialize in the diagnosis and treatment of diseases of the digestive tract.

ASGE is deeply concerned that the Medicare program continues to be the target for budget cutting, with little thought given to the impact on quality and access to care. Continuing in this direction could undermine the confidence that patients, physicians, and hospitals have in the program and lead to different levels of care based on age.

Two options for budget savings were recommended by the Physician Payment Review Commission. The first is a reduction in the Medicare Economic Index update to prevailing charges. The second option would reduce prevailing charges for a list of nine procedures regarded as overpriced. A third option that was rejected is reduction in payments to new physicians as proposed in the President's budget.

ASGE is concerned that the methodology developed by the Commission to identify overpriced procedures is not sufficiently developed to predict accurately which, if any, procedures are overpaid. Substantially more work needs to be done in this analysis in order to prevent erroneous decisions from being made. The approach designed by the Commission raises interesting questions, but should be reviewed carefully before implementation.

ASGE is also concerned that the proposal to reduce payments for selected procedures contradicts the statutory and regulatory standards for "inherent reasonableness" analysis that apply to the Health Care Financing Administration. Two sets of standards to accomplish the same goal would not seem to be necessary.

It seems as if the real basis for the Commission's list is the volume of the selected procedures that are performed. Issues of the volume of the procedures raise a series of different questions related to the medical necessity for the procedure. In ASGE's view, a procedure that is inappropriately or unnecessarily performed should not be compensated. To that end, ASGE has developed standards for the appropriate use of gastrointestinal endoscopy that if followed would eliminate unnecessary procedures. ASGE believes that well-trained endoscopists observe these standards, and that among those physicians with proper training, the incidence of unnecessary procedures is very small. It may well be that people with inferior training are performing them, and, as a result of their poor training, are performing them inappropriately. As noted earlier, these are not issues of payment levels but are questions of education, training, indications for use, and appropriate behavior by physicians.

Although ASGE recognizes the budget pressures that Congress operates under, it is inappropriate to attack a procedure simply because of volume. Mechanisms are in place to review the appropriateness of care given in hospitals and should be vigurously pursued.

It would be ASGE's preference that further short-term cuts in the Medicare program not be made. We recognize the need to contain the program's growth and we believe long range steps, such as development of fee schedules and the analysis of resource inputs, will help in that regard. Arbitrary budget cutting, however, does not really deal with the long term issues. Nonetheless, ASGE recognizes that the Committee must make recommendations to Congress to reduce spending in Part B of Medicare. In our view, the least problematic means would be an adjustment to the Medicare Economic Index. While no one is enthusiastic about a "freeze", we are even less enthusiastic about the proposals to cut payments for one procedure or another because of an unsubstantiated view that the price is too high. At least an adjustment in the MEI spreads the injury around so that no one physician has to suffer a disproportionate cut in reimbursement in the Medicare program.

ASGE has looked at the President's proposal regarding new physicians and their payments but is unable to offer comments because ASGE has not had the opportunity to evaluate its impact on physician distribution and beneficiary access to care. ASGE would be concerned if, for example, new physicians were discouraged from practicing in areas where reimbursement is lower knowing that their payments would be cut even below those already depressed rates. We believe that more analysis of the potential outcome of this proposal needs to be made before action by Congress.

ASGE recognizes that modification to the physician payment mechanism under Medicare will probably take place and with that modification there will be discomfort and dislocation. We are concerned, however, that the discomfort and dislocation will precede the modification and the necessary study. ASGE believes that Congress should adopt a more prudent course at this time. Any immediate savings should be taken in a simple and relatively painless way, such as by an adjustment to the MEI. Serious modifications in payments should be deferred until Congress and other interested parties have analyzed all the issues. For example, we are aware that there is continued discussion about the geographic variations in payment. Certainly this is an issue that should be looked at, and more work should be done to develop a methodology for doing so.

A major concern of ours is the fact that short-term budget needs often overcome the policy considerations that need to be looked at. We believe that an acceptable forum needs to be put into place that can be insulated from short-term budget pressures. We suggest separating policy from budget in such a way that policy can be reviewed, the parties can come together and debate, and suggestions can be returned to Congress. Perhaps the Physician Payment Review Commission can play such a role.

While budget goals certainly are one aspect of that overall debate, they cannot be the only aspect of that debate. There must be a continuing commitment to maintaining the viability of the Medicare program for the patients. That means there must be sufficient resources available for the physicians, hospitals, and other providers of care.

In conclusion, ASGE reiterates its concern that the Medicare program continues to be sliced up simply to meet the demands of the deficit. Issues of program quality and access are being overlooked in the rush to find savings. ASGE is especially concerned that the proposal to cut back on payment of selected procedures is being advanced without sufficient analysis and with insufficient data. Congress should not adopt that proposal at this time.

Finally, an appropriate forum should be created to allow interested parties to come together to try to work out some of these policy problems in a fashion insulted from immediate budgetary pressures so that effective policy can be devised.

ASGE appreciates the opportunity to present its views.

STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE

WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON HEALTH

FOR THE RECORD

OF THE JUNE 15, 1987 HEARING

ON

FISCAL YEAR 1988 BUDGET ISSUES UNDER THE MEDICARE PROGRAM

INTRODUCTION

The American Society of Internal Medicine (ASIM) appreciates the opportunity to share with Congress the views of internists throughout the country on proposals to cut FY 1988 spending on services covered by the Medicare Part B program.

ASIM believes that short-term changes should follow the same principles and move the payment system in the same direction as long-term reform. As ASIM has stated in the past, the Society believes that principles and goals identified in the Physician Payment Review Commission's March 1, 1987 Annual Report to Congress are appropriate and desirable. The Society particularly supports the Commission's goal that "reforms in the levels and methods of payments should increase equity among physicians, so that similar payments are made for similar services among similarly qualified physicians. Payments for different services should broadly reflect relative cost, market conditions, and other appropriate factors." The Society also strongly agrees with the Commission's finding that "current differences in relative charges for physician services provide distorted signals to physicians and cause serious inequities among physicians" and that "fee schedules under Medicare should be designed in such a way that the relative payments for services would differ from the pattern of allowed charges under the current system." Although ASIM has had serious concerns that the Administration intends to use "inherent reasonableness" simply as a measure to achieve short term budget savings, instead of bringing about greater rationality into the payment system, the Society generally agrees with the Commission's March 1 statement that inherent reasonableness should have the following goals:

- to address distortions in allowed charges that have arisen for the application of customary, prevailing and reasonable (CPR) reimbursement principles, and

- to achieve short-term budget savings in ways that are more consistent with long-term policy directions than are across-the-board reductions in payments.

As the Commission noted in its March 1 report, however, the application of inherent reasonableness should increase allowable charges for some services as well as reduce allowable charges for others.

The challenge now for the Commission, Congress, physicians, beneficiaries, and others is to find a formula to attain budget savings that is consistent with the goals and findings expressed in the Commission's March 1 report to Congress. The following recommendations, ASIM believes, are the most consistent with the Commission's and Congress' long-term policy objectives, given the rather limited choices available today.

RECOMMENDATIONS

1. **Selective reductions in prevailing charges for certain overvalued services is far more consistent with the goals of long-term reform than uniform across-the-board freezes or reductions in prevailing charges for all services.** ASIM strongly believes that a uniform across-the-board reduction in the amount by which prevailing charges are updated by the Medicare Economic Index (MEI) would exacerbate the distortions and inequities in the existing system of payment, harm the availability and quality of medical care provided to Medicare beneficiaries, and thus would represent a significant step backwards away from the goals of true physician payment reform.

   In its March 1 report to Congress, the Commission acknowledges that "the CPR method has generated a distorted price structure that leads to inappropriate patterns of medical care and inequities among categories of physicians. These inequities may affect styles of practice because they provide inappropriate financial incentives that influence such decisions as what services to employ in the care of patients, where to practice, and whether to specialize. These distortions can also reduce access to care and quality of care as well as increase Medicare program costs." The fact that certain primary care, cognitive services--such as office, nursing, and home visits--are grossly undervalued under Medicare's existing system of payment has been borne out by several important studies, including the 1985 Massachusetts resource-based relative value scale (RBRVS) study cited by the Commission as one indicator that certain services under Medicare may be overpriced. Significantly, that study found that certain cognitive services are undervalued by two to three fold compared to surgical services.

   Moreover, a random survey of ASIM members nationwide in 1986 revealed that *Medicare prevailing charges in most localities for a routine return visit are set at a level that barely exceeds, if at all, the overhead costs of providing that service. Therefore, physicians who currently provide that service at the Medicare prevailing charge level receive virtually no compensation for their time and effort involved in providing the service.* This finding, although disturbing, is not entirely surprising, given the fact that primary care physicians in recent years have absorbed the dual blow of the historical undervaluation of their primary care, cognitive services coupled with a freeze on payment levels at a time when their costs have risen steadily. As a result of the congressional imposed Medicare fee freeze, Medicare payment levels for non-participating physicians in 1987 are only 3.2 percent higher than what physicians were charging in 1983--a four year gap between Medicare payment levels and physician charges.

   Therefore, a uniform across-the-board reduction or freeze in Medicare prevailing charges for all physician services would perpetuate the existing distortions in the CPR payment methodology; further diminish the value that Medicare places on time-consuming, cognitive and primary care services; undermine the ability of physicians to continue to provide those services to their Medicare patients; and be inconsistent with the Commission's own stated objectives for long-term reform. Therefore, ASIM strongly urges Congress to allow full Medicare Economic Index (MEI) increase in prevailing charge levels for cognitive services such as office, nursing, and home visits in the next January 1, 1988 update. If Congress concludes that it is necessary to reduce FY 1988 expenditures for Part B physicians services, then interim selective cuts in payment for certain services would be preferable.

2. **In making selective cuts in payments, it is preferable to target prevailing charges in those localities where payment levels are disproportionately high even after taking into account legitimate differences in costs of practice, than to cut all prevailing charges nationwide for those services by 10 percent uniformly across the board. If this is not feasible to implement, it still is preferable to reduce payments for selected overvalued services than to reduce prevailing charges for all physician services, while continuing to study ways to address geographic inequities.**

   The Physician Payment Review Commission has proposed to reduce prevailing charges for selected procedures regarded as outliers uniformly across-the-board. Although ASIM recognized that this may be the simplest approach to reducing

outlays, ASIM believes that uniform reductions are not the best way to move the system toward the Commission's own goals for long-term reform. As the Commission itself noted in its discussion of geographic variations in the March 1 report to Congress:

> "The current payment system is inequitable in that physicians with comparable training and experience can receive substantially different payments for providing the same service, a pattern that persists even after accounting for cost of practice or cost of living differences. *This inequity is exacerbated when across-the-board reductions in payment constrain all physician fees, high and low alike.*" (Emphasis added)

Therefore, the Commission's suggestion that prevailing charges for certain services be uniformly reduced by 10 percent across-the-board would tend to result in the same inequities cited in the March 1 report.

A better way to selectively reduce prevailing charges for overvalued services is to target reductions for those overpriced services toward those localities where current payment levels are disproportionately high even after taking into account legitimate differences in the cost of practice, rather than unfairly penalizing physicians in localities that have kept prices down. Cuts targeted primarily toward those disproportionately expensive prevailing charge localities could be established at a level that attain the same savings as an across-the-board 10 percent cut in prevailing charges for the same services. Although ideally those higher priced areas should be identified by a new cost of practice and living index that measures relative differences, by locality, in practice costs, an interim approach might be to set a nationwide ceiling on Medicare payments for those overvalued services at some acceptable percentage above national mean adjusted prevailings for those services, so that prevailing charges in "outlier" localities would be reduced to that ceiling.

It is important to emphasize that ASIM does not support the proposal offered by some groups to limit prevailing charges for all physician services by statewide or national screens on prevailing charges. By applying state and national prevailing charge limits on all physician services, in essence creating a state-by-state charge based RVS, the current disparity in reimbursement between physician's cognitive services--such as office, nursing, and home visits--and high technology procedural services will be exacerbated. This is because limits on Medicare prevailing charges for all services would, by definition, reduce Medicare's "approved amount" for office, nursing, home visits and other cognitive and primary care services in those localities that pay some percentage above the state or national norm. Therefore, rather than improving reimbursement for those undervalued services, reimbursement levels in many localities for those services would be reduced. Depending on the magnitude of the reduction and how large the gap is between current Medicare prevailing charges and what would be a fair fee for those cognitive services, the effect of this proposal could be to make it impossible for internists in some localities to continue to provide those services at Medicare's approved amount. Appended to this statement is a letter from ASIM to the Commission explaining our views on this subject in greater detail. We respectfully request that it be included in the official record of this hearing.

3. **The methodology used by the Physician Payment Review Commission for identifying potential selective cuts--comparing several existing relative value scales (RVSs) against Medicare prevailings for only four states--is at best an imperfect approach that cannot substitute for the kind of careful deliberative methodology used in the current Harvard study.**

ASIM believes that the RVSs used by the Commission to identify services that may be overpriced under Medicare are of limited utility. Unlike the current Harvard RVS study, the relative value scales cited by the Commission in its May 14 letter were never intended as or designed to serve as a benchmark for evaluating the appropriateness of Medicare payment levels for specific services. Without knowing more about the details of how each RVS was developed, where it is being used, and the precise methodology employed for determining relative values, ASIM questions whether or not they truly represent an expert judgment on what the appropriate relative values should be for selected physician services. Moreover, ASIM questions the wisdom of comparing those relative values with the computed weighted Medicare allowed charge for each procedure using data from only four states

(Wisconsin, Washington, Connecticut, and Alabama), since national mean adjusted prevailing charge data presumably would provide a far more accurate picture of existing relative values under Medicare. In addition, the use of 1984 Medicare charge data is suspect, since many areas of the country had not yet converted to the HCFA Common Procedure Coding System (HCPCs) or were in the process of doing so. Therefore, some of the apparent discrepancies in relative values may represent coding problems, not true distortions in the pricing structure.

Notwithstanding the above concerns, however, ASIM recognizes that the Commission is utilizing the best available data today in determining whether or not certain services may be overvalued. The Society strongly urges Congress, however, to view the Commission's findings as at best an interim and imperfect benchmark for comparing relative values, not as a substitute for the kind of careful deliberative process being used by the Harvard study. In addition, the Society hopes that the Commission and Congress will be responsive to reviewing alternative data offered by various groups that may lead to a somewhat different conclusion than the Commission's findings.

ASIM has reviewed the specific proposed cuts identified by the Commission. The Society believes that it lacks sufficient data at this time to evaluate the appropriateness of the specific cuts proposed for services rendered by physicians in other specialties, although ASIM believes that the Harvard study currently in progress will eventually provide us with the necessary data to make such judgments. Given the fact, however, that many internists provide diagnostic colonoscopy--one of the services originally identified by the Commission as a potential target for cuts--the Society does feel qualified to offer some suggestions on how to reduce inappropriate outlays for that service, although we understand that the Commission has decided to not propose cuts in payment for this service at this time.

4. **As an alternative to a uniform reduction in prevailing charges for diagnostic colonoscopy, Congress should support changes in the coding system that would minimize inappropriate upcoding of services in order to obtain higher reimbursement under Medicare.**

Based on the data presented by the Commission, diagnostic colonoscopy under Medicare is reimbursed at a level that is only nominally above what appropriately should be the case under a resource-based RVS. The 1985 Massachusetts study valued diagnostic colonoscopy at 0.36 while Medicare's prevailing charges are valued at 0.39--a less than 8 percent differential. Therefore, without further data, ASIM does not believe that a strong case has been made that diagnostic colonoscopy--when coded and billed appropriately-- is grossly overvalued based on resource costs.

The Society recognizes, however, that significant problems exist because of the coding for diagnostic colonoscopy--problems that ASIM believes have resulted in an inappropriately high volume of claims submitted for this service. Correcting such coding problems, would be a far more fruitful avenue to pursue in seeking ways to reduce unnecessary Part B expenditures for the service. ASIM believes that much of the high utilization of diagnostic colonoscopy--CPT code 45360--and the apparently wide variations in Medicare prevailing charges for this service across the country are due to some physicians inappropriately coding for less intensive (and less expensive) routine diagnostic sigmoidoscopy as "diagnostic colonoscopy" in order to obtain higher reimbursement.

Specifically, some physicians appear to be inappropriately upcoding routine diagnostic sigmoidoscopy (codes 45330-45336) as a diagnostic colonoscopy (codes 45360-45370). This coding practice has been encouraged, at least in some localities, by Medicare carriers as a way to correct inequitable payment levels for routine sigmoidoscopies. Recently, the American Medical Association (AMA) CPT-4 Editorial Advisory Panel, on the recommendation of several gastroenterology advisors, decided to eliminate codes 45360-45370 (diagnostic colonoscopy) in the next editions of CPT-4. By doing so, physicians no longer will be able to "upcode" for routine flexible sigmoidoscopy (codes 45330-45336)--which currently is reimbursed on average by Medicare at approximately $75-100--as diagnostic colonoscopy, codes 45360-45370, which currently pays on average around $300 in most localities. In lieu of deleted codes 45360-45370, physicians would use codes 45378 (colonoscopy, fiberoptic, spleenic flexure, diagnostic procedure) when beyond

the spleenic flexure and codes 45330-45336 when up to the spleenic flexure--a clear distinction in the level of service that should eliminate most "upcoding" of services to receive higher payment.

ASIM strongly believes that this change will save Medicare far more money than a 10 percent across-the-board reduction in prevailing charges for diagnostic colonoscopy, since it would target the true problem: an inappropriately high volume of charges in some localities for more expensive diagnostic colonoscopy procedures that appropriately should be billed and reimbursed as routine flexible fiberoptic sigmoidoscopies. A modest upgrading in reimbursement for routine sigmoidoscopies (45330-45336), coupled with the elimination of codes 45360-45370, would eliminate the incentive and means for physicians to abuse the system by upcoding for this service. *Therefore ASIM strongly urges Congress to: (1) support (in lieu of a reduction in prevailing charges for diagnostic colonoscopy) the decision by the AMA CPT-4 Editorial Advisory Panel to eliminate codes 45360-45370 to reduce inappropriate upcoding of services; and (2) authorize a modest upgrading of reimbursement for codes 45330-45336 to assure appropriate reimbursement for those services and to eliminate the incentives for inappropriate upcoding of services.*

5. **In addition to making interim downward adjustments in payment for selected overvalued services, Congress should ask the Commission to conduct an analysis and advise Congress on services that are undervalued under the existing Medicare CPR system. If this cannot be accomplished in time for the current budget cycle, ASIM strongly urges the Commission to conduct this analysis and make recommendations to Congress in time for next year's budget.**

ASIM is pleased that the Commission expressed its intent to extend the comparative analysis to visits and to low price services generally, rather than focusing simply on identifying procedures with high charges that are out of line. The Society believes, however, that in order for the Commission's actions to have credibility with the medical profession and beneficiaries, and to be consistent with the goals of long term reform, this type of analysis must be performed as expeditiously as possible. Congress should specifically request the Commission to perform this analysis within a reasonable time frame in order for it to be incorporated into the next budget cycle.

6. **Congress should consider the potential adverse impact on the quality and availability of patient care of continued reductions in expenditures on physicians services under Medicare.**

The Medicare program has been forced to absorb major reductions in projected outlays over the last several years in order to meet budget targets established by Congress. Although ASIM recognizes the urgency of reducing the federal deficit, the Society is concerned that continued cuts in expenditures on physician services under Medicare will sooner or later have a detrimental effect on the quality and availability of patient care. Already, as noted earlier, primary care physicians are finding it increasingly difficult to provide time consuming, high overhead cognitive services--such as office, nursing, and home visits--at the payment levels permitted by Medicare. Thus far, the commitment of physicians to continue to provide their patients with the best care possible has minimized any real damage to the quality of patient care resulting from the budget cuts.

But sooner or later, continued reductions in spending will force physicians to change their practice styles, by spending less time with patients, seeing fewer Medicare patients, reducing acceptance of assignment, or discontinuing certain services in their offices because they no longer can afford to provide them for Medicare's payment levels. No physician wants this to occur. But unless there is a redirection of national priorities and resources towards improving the quality and availability of care provided to Medicare patients, ASIM fears that this will be the eventual outcome of continued budget cutting. The Society urges Congress to forego unnecessary and dangerous short-term cuts in Medicare payments for patient care. At a time when the Administration seems to be more concerned with reducing federal outlays than protecting the quality and availability of care provided to Medicare patients, somebody must speak out for the interests of those who will be hurt by those cuts. This Committee, ASIM believes, can begin to sound that cautionary note by rejecting short-term, ill-considered measures to further cut Medicare Part B expenditures.

CONCLUSION

In conclusion, ASIM pledges to work with Congress and the Commission on the difficult task of identifying ways to meet nation's budget priorities in a manner that is consistent with long-term reform. Protecting high overhead, undervalued primary and cognitive services--particularly office, nursing, and home visits--from further cuts in payment, targeting certain overpriced services for appropriate reductions; and, if necessary, freezing payment levels for other (non-primary care) services appears to be the most equitable formula for achieving savings in a manner that is consistent with long-term reform. Such approaches, however, must continue to be viewed as modest interim measures that, at best, fall far short of the true goal of bringing greater rationality in the physician payment system through a careful realignment of relative values for cognitive and procedural services. They must also be carefully evaluated in the light of the potential damage to patient care that may result from continued short-term budget cuts. Most importantly, the Society strongly urges Congress to focus most of its energy and resources on bringing about long-term reform of the physician payment system, rather than concentrating unduly on finding ways to achieve short-term budget savings.

G-BD-0777

TESTIMONY OF MARTIN A. COHN, M.D., MT. SINAI MEDICAL CENTER, SLEEP DISORDERS CENTER, MIAMI BEACH, FLORIDA, ON BEHALF OF THE ASSOCIATION OF PROFESSIONAL SLEEP SOCIETIES

Mr. Chairman and Members of the Subcommittee, the Association of Professional Sleep Societies is pleased to present our views concerning physician payment under the Medicare Program. As you well-know, our population's age distribution is shifting towards the elderly. Each year, a greater proportion of our medical practices are comprised of Medicare patients. The elderly have more diseases as a group and are individually more likely to have multiple diseases. New technologies can diagnose and treat those elderly at risk for medical catastrophes before death or disability claim their tolls in quality of life and Medicare expenditures. The control of high blood pressure is just one example. During your subcommittee's consideration of options for cuts in the Medicare program to achieve reconciliation targets, I believe it is vital that you remember that Medicare is designed and intended to provide top care to our nation's elderly. Every technological and scientific advance that is available to the medical community should be utilized to insure good health and longevity for our aged citizens. Too often decision-makers look at the Medicare program as a numbers issue. But those numbers translate into health care coverge and Medicare policy.

My specific message to you today is that many diseases, particularly those of the heart and lungs, change for the worse on a nightly basis during sleep. In people over 65 years of age, most disease-related deaths and disease-related medical catastrophes (such as heart attack and stroke) occur during the hours of sleep. Any reimbursement proposals for physicians, such as prospective plans based on Diagnostic Related Groups, or specific cuts in allegedly over-utilized procedures must recognize the 24-hour nature of disease and accordingly provide for responsible care. Current and proposed Medicare guidelines and payment policies force the health care system into short-sighted treatments because patients cannot afford the necessary tests for sleep related abnormalities. A further ratcheting down of these policies in the name of cost containment would present additional likelihood of catastrophe.

Most sleep disorders centers are run by specialists in internal medicine who have studied for additional accreditation in diagnosing and treating sleep disorders. The emphasis on internal medicine and specialized training stems from the fact that most frequent sleep disorders are associated with life-threatening cardio-pulmonary problems during the night, such as sleep apnea, asthma, heart disease and chronic obstructive pulmonary disease.

Our ability to differentially diagnose patients with sleep complaints has progressed rapidly in the past ten years. We now have well-accepted guidelines and rationales for treating sleep disorders with surgery, mechanical devices, medication or some combination of these approaches. There is broad consensus as to the life-threatening nature of cardio-pulmonary abnormalities in sleep and risks of falling asleep while driving a vehicle or operating dangerous machinery. Furthermore, recent studies indicate that over 90% of the patients evaluated by sleep disorders centers are significantly improved by recommended treatments. The great impediment that we face as clinicians is that the elderly are reluctant to seek out our expertise because Medicare already pays so little for the costs associated with testing. This fact has recently been supported by reports from members of the Association of Professional Sleep Societies. I will describe two types of life-threatening, yet treatable, medical conditions. For both, current Medicare policy effectively prevents treatment due to inadequate reimbursement.

Inappropriate use and overuse of sleeping pills is particularly common in elderly, Medicare patients. Many patients began such treatments years before modern knowledge was available. Most of the prescriptions for sleeping pills are written for this category of patients. Research indicates that cardio-pulmonary disorders, also common in the elderly, are exacerbated by sleep and account for the disproportionate number of medical catastrophes that occur during the night. Sleeping pills enhance the depression of respiration and cardiac function that normally accompanies sleep. Inappropriate use of sleeping pills in the elderly may also contribute to confusion and locomotor problems and thus potentiate accidents and falls. This vicious cycle can now be broken with rational approaches to problems of sleep in the elderly.

Second is the major problem surrounding people who cannot stay awake to function. Such patients often take prescription stimulants, to help them stay awake when driving a vehicle or during activities that require sustained alertness. The United States Senate, in report #99-152 accompanying the fiscal year 1986 Appropriations Bill for the Department of Transportation, has recognized the potential impact these disorders have on highway safety. Stimulants, such as amphetamines, are proper treatment for only 10% of the people who have prescriptions for stimulants. For example, the most common cause of an inability to stay awake in the day is the disorder of sleep apnea which is characterized by symptoms of loud irregular snoring and high blood pressure. Stimulants are medically inappropriate for such patients. Now we know how to correctly diagnose conditions of excessive somnolence and provide appropriate treatment for the millions of Americans with these symptoms, but in many cases Medicare policy prevents this important diagnosis.

We ask that this Subcommittee carefully review reimbursement practices for Medicare patients and suggest that revisions to the Medicare Guidelines be made which are in line with present knowledge and standards of practice. As a further policy recommendation, we do not believe it is advisable to increase Part B premiums or raise deductibles, unless a comprehensive benefit is added, such as the pending proposal that would establish catastrophic health care coverage. Right now, access and affordability are major obstacles to many elderly persons seeking health care.

Thank you for the opportunity to present our views.

STATEMENT OF

FORMER CONGRESSMAN JAMES ROOSEVELT

CHAIRMAN OF THE

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. Chairman, I am James Roosevelt, chairman of the National Committee to Preserve Social Security and Medicare, and I represent over four million Americans, most of whom are Medicare beneficiaries and therefore are frequently forced to pay extra charges on non-assigned claims for doctor fees. Our statement today is similar to our statement of May 7 which urged Congress to pass H. R. 1923 which would make assignment mandatory for doctors who treat Medicare patients. Mandatory assignment protects seniors from the $3 billion financial burden of these extra charges at no cost to the budget. It also will bring doctors to the bargaining table to negotiate fair fees for Medicare-covered treatment because they will no longer be able to charge higher fees than Medicare approves.

National Committee members frequently write me of their dismay and anger with uncontrollable out-of-pocket costs for doctor fees caused when their doctor does not accept assignment. They don't understand why Medicare pays only 50 percent of their doctor bills when they were told that Medicare would pay for 80 percent. Usually they cannot get their private medigap insurance, if they have it, to pay for extra charges, which average over $33 a claim. And it is frequently up to beneficiaries rather than the doctor to fight for appropriate reimbursement when the seriousness of their condition justifies a larger than average payment.

In some cases, Medicare's approved charge may be unreasonably low. But in many cases, we believe that non-participating doctors are overcharging, adding to their $100,000 average income an extra $7,500 a year at the expense of senior citizens. In either case, Medicare beneficiaries are caught in the middle.

The participating doctor program, enacted in 1984, has helped beneficiaries find doctors who always accept the Medicare-approved charge as full payment, thus limiting their out-of-pocket costs to 20 percent of the approved amount. But almost 75 percent of this nation's doctors refuse to join the participating physician's program. Even though overall assignment rates increased in 1985, both assignment rates and the number of participating doctors now have begun to drop.

The participating doctor program, while helpful, does not solve the problem of extra charges. As a general rule, seniors are reluctant to disrupt long-standing relationships with their doctors even if they don't accept assignment. In some areas of the country, only a few doctors are participating doctors. In rural areas, many seniors have little or no choice of doctors.

For example, in 1986, physician participation rates ranged from eight percent in South Dakota to 54 percent in Alabama. Looking at just those states known as retirement centers, the participation rate was 15.4 percent in Arizona, 25.7 percent in Florida and 30 percent in California. Put another way, even if he or she has time to shop around, a senior citizen in California has a less than a one-in-three chance of locating a physician who won't charge in excess of the Medicare-determined reasonable fee. But that's double the chances of the senior citizen living in Arizona!

Even the most careful medical care shopper can be caught up short by the present system. As one of our members reported, he and his wife sought out a participating physician and were fortunate to locate a reputable doctor in whom they had confidence. Nevertheless, when the wife was hospitalized, the additional specialists called in to care for her were not participating doctors and did not accept assignment. "She was too sick to even lift up her head," the husband wrote. "I couldn't be there full time. Was she supposed to ask everyone who came in the room if they would accept the Medicare payment? And what could we have done even if we had known they would refuse?"

As a consequence, the National Committee urges Congress to pass H. R. 1923 introduced by Congressman Brian Donnelly and make assignment mandatory for doctors who treat Medicare patients. With Medicare reimbursement averaging 18 percent of doctors' incomes and with increased competition for patients, most physicians cannot afford to lose Medicare patients. To assure senior citizens access to quality medical care in all cases, the National Committee will also be urging states to pass licensing laws, similar to one in Massachusetts, requiring doctors to accept assignment from Medicare beneficiaries.

Many doctors refuse to accept assignment because they claim that Medicare-approved charges are not fair. We certainly agree that the current payment system distorts the market for doctors' services because it encourages them to raise their fees, to choose specialty practices rather than primary care practices and to practice in higher income urban areas rather than rural or low-income areas. Across the board freezes also tend to punish doctors who have kept their fees reasonable all along and do nothing to roll back exorbitant fees of other doctors.

Whether Medicare-approved fees are fair or unfair, we believe no better system will be designed and implemented until doctors are required to accept assignment from Medicare for every claim. As long as doctors have the option of refusing direct payment from Medicare and billing patients for more than the Medicare-approved charge, they have little or no incentive to negotiate for a more equitable payment system. If the current system is faulty, the National Committee believes it is the responsibility of doctors to work with Congress and the Administration for payment reform.

If the interests of Medicare beneficiaries are to come ahead of the interests of the medical profession, the first thing Congress should do is make assignment mandatory.

Thank you.

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